

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 05/28/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER MARQUETTE	STREET ADDRESS, CITY, STATE, ZIP CODE 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	<p>This visit was for a Recertification and State Licensure Survey. This visit included a State Residential Licensure Survey. This visit included the investigation of Complaint IN00170323.</p> <p>Complaint IN00170323-Unsubstantiated due to lack of evidence.</p> <p>Survey dates: May 18, 19, 20, 21, 22, 26, 27 and 28, 2015.</p> <p>Facility number: 000105 Provider number: 155198 AIM number: N / A</p> <p>Census bed type: SNF: 64 Residential: 57 Total: 121</p> <p>Census payor type: Medicare: 9 Other: 55 Total: 64</p> <p>Sample: 5</p> <p>These deficiencies reflect state findings cited in accordance with 410 IAC 16.2-3.1.</p>	F 0000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards 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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155198	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____		X3) DATE SURVEY COMPLETED 05/28/2015
NAME OF PROVIDER OR SUPPLIER MARQUETTE			STREET ADDRESS, CITY, STATE, ZIP CODE 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 0157 SS=G Bldg. 00	<p>483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a).</p> <p>The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section.</p> <p>The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member.</p> <p>Based on observation, interview and record review, the facility failed to notify the physician of lack of bowel movements and diarrhea stools for 7 of 9 residents reviewed for notification of</p>	F 0157	F 157 We respectfully request a face to face IDR for F157. Resident #39 had history of chronic loose stools from her admission to Health Center on 1/26/15. Stools within the	06/27/2015	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155198	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 05/28/2015
--	---	---	---

NAME OF PROVIDER OR SUPPLIER MARQUETTE	STREET ADDRESS, CITY, STATE, ZIP CODE 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
	<p>change of condition. (Residents #39, #12, #105, #115, #136, #192, and #65). This deficient practice resulted in Resident #39 being hospitalized with a diagnosis of acute short lived encephalopathy and dehydration. Resident #12 had 8 days without a bowel movemet with no physician notification and was admitted to the hospital with a fecal impaction 11 centimeters.</p> <p>Findings include:</p> <ol style="list-style-type: none"> On 5/27/15 at 10:56 a.m., the record review for Resident #39 was completed. Diagnoses included, but were not limited to, dementia with delusions, depression, constipation, anemia and high blood pressure. <p>The Elimination Record indicated the following:</p> <p>3/1/15 through 3/4/15 (4 days)- there was no elimination documentation recorded. 3/5/15- Extra Large Loose bowel movement and a medium soft formed bowel movement. 3/6/15- Extra Large softly formed x 2, one Extra large loose and one small loose stool. 3/7/15- Extra Large soft formed stool 3/8/15- One medium loose stool. One Extra large and one large softly formed</p>		<p>community were not diarrhea but described as loose. Per Bowel Protocol, physicians would not be notified until all steps of the protocol had been completed. While hospital diagnosis indicates dehydration, her labs then were unchanged from her admission labs. Resident # 12 had reported BM on 5/11/15, she was given MOM on day of discharge to the hospital. The fecal impaction listed was not diagnosed at the hospital until 5/18/15. The Bowel protocol does not require physician notification until all steps of the protocol have been performed. None of the resident's identified met those criteria. F 157 483.10 (b) (11) Notification of Changes</p> <p>What corrective actions will be accomplished for those residents found to have been affected by the deficient practice? #39: Resident's record was reviewed. Record review showed bowel patterns were unchanged from time of admission until time of emergency room visit on 3/10/2015. Facility documentation shows resident had bowel movements on 3/1/15, 3/2/15, 3/3/15, and 3/4/15. Facility completed the hydration risk assessment; resident was not identified at risk for dehydration. Resident was sent to ER on 3/10/15 after an unresponsive episode. NP assessed Resident at the time of unresponsive</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155198	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 05/28/2015
--	---	---	---

NAME OF PROVIDER OR SUPPLIER MARQUETTE	STREET ADDRESS, CITY, STATE, ZIP CODE 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
	<p>stool.</p> <p>3/9/15- Extra Large softly formed stool.</p> <p>3/10/15- One medium softly formed stool and one extra large and one large loose stool.</p> <p>The Medication Administration Record dated February 2015, indicated the resident received Senna 8.6-50 milligrams daily (a medication to assist in bowel movement), was given as ordered between March 1-10 when the resident was having large loose stools.</p> <p>The nurses notes for March 2015 had no documentation regarding notification of the physician regarding the frequency of loose stools. The resident had an episode of unresponsiveness on 3/11/15 which resulted in her being sent to the hospital.</p> <p>The resident was sent to the hospital on 3/11/15, and the discharge summary indicated, "...Discharge Diagnoses 1. Acute short lived encephalopathy, most likely related to dehydration from diarrhea. 2. Syncopal episode. The patient hardly arousable, patient quite dehydrated. 3. Dehydration 4. Diarrhea, no stools since she has been here in the hospital...5. Acute kidney injury, Creatinine 1.6, now down to 1.1...8. Dementia...Observation Summary:... who was in her normal state</p>		<p>episode; assessment documented in Progress note, including assessment of oral mucosa that displayed no signs/symptoms of dehydration. Resident was assessed in ER and sent back to the facility; no hospitalization required. Resident displayed no negative outcomes from the alleged deficient practice as evidence by clinical data. Resident's hospitalization was a result of an unrelated acute condition change with proper physician notification, assessment, and evaluation. Resident continues to thrive in long term care setting. #12: Resident no longer resides at Marquette. Resident displayed no negative outcomes from the alleged deficient practice as evidence of clinical data. Records show the bowel protocol was implemented. The fecal impaction was not present at the time of hospital admission per hospital documentation and physician assessment. The fecal impaction was diagnosed after changes in abdominal assessment 3 days into hospital stay. Physician notes indicate fecal impaction in rectum possibly related to bladder distention/wall thickening associated with suspected cancer. Urinary obstruction was also not identified as problematic until 5/17/2015. An indwelling catheter was placed at that time. Family opted not to have further testing to identify prognosis.</p>	

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 05/28/2015	
NAME OF PROVIDER OR SUPPLIER MARQUETTE				STREET ADDRESS, CITY, STATE, ZIP CODE 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			
	<p>of brain function before lunch yesterday when her grandson came back about 45 minutes later and found that she was not easily responsible[sic]...She was seen by a provider at [name of facility] who told the grandson that he saw no focal neuro findings, The patient had no focal neuro findings when she came here, but was found to be quite dehydrated... patient felt much better with fluid hydration and had no further syncopal episode...."</p> <p>The nurses notes for February and March 2015, had no documentation regarding notification of physician regarding the frequency of loose stools.</p> <p>As of exit on 5/28/15, there was no information regarding notification of physician regarding loose stools provided.</p> <p>2. The record for Resident #12 was reviewed on 5/22/15 at 1:06 p.m. Diagnoses included, but were not limited to, fecal impaction, urinary obstruction, hematemesis, hemorrhagic cystitis, and anemia.</p> <p>The resident did not have BM's documented for the following days: 5/8/15 through 5/15/15 (8 days)</p> <p>No documentation was found in the</p>		<p>Resident transferred to hospice services on 5/19/2015 during hospital stay. Resident re-admitted to facility for ongoing management of end of life care. #105: Resident no longer resides at Marquette. Review of records was conducted. Resident did not admit to facility until the evening of 4/16. Records show that this independent, continent Resident had no documented bowel movement x72 hours. Resident had a BM on day shift the following morning, therefore interventions were not needed, notification not indicated per policy. Records show that this Resident had no bowel movement from 5/17-5/20/2015. Resident discharged to home the morning of 5/20/2015, therefore interventions would not have been implemented, MD notification not indicated. Resident displayed no negative outcomes from the deficient practice and has successfully discharged to home. #115: Resident's record was reviewed, no interventions needed. Resident displayed no negative outcomes from the alleged deficient practice and continues to thrive in long term care setting. #136Marquette. Resident displayed no negative outcomes from the alleged deficient practice and has successfully discharged to home. #192: Resident no longer resides at Marquette. Resident displayed no negative</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155198		X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____		X3) DATE SURVEY COMPLETED 05/28/2015	
NAME OF PROVIDER OR SUPPLIER MARQUETTE				STREET ADDRESS, CITY, STATE, ZIP CODE 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			
	<p>resident's record to indicate the physician was notified she had not had a BM in over 3 days.</p> <p>The resident's physician orders dated May 2015, included, but were not limited to, the following orders: 7/22/13--Milk of Magnesia (a laxative medication) 400 mg (milligrams) /5 ml (milliliters) (30 ml) by mouth as needed for constipation daily.</p> <p>No abdominal assessments were found documented for the days the resident did not have a BM.</p> <p>Resident #12's record lacked documentation to indicate PRN laxatives were administered when she went without a BM longer than 3 days.</p> <p>A Nursing progress note dated 5/16/15 at 4:56 a.m., indicated the resident was admitted to the hospital.</p> <p>A CT Scan of the Abdomen and Pelvis without contrast report dated 5/17/15, indicated, "...There is a very large amount of colonic stool distending the rectum to a diameter of 11 cm consistent with fecal impaction. There is additional stool present in the right colon along with moderate gaseous distention...."</p>		<p>outcomes from the alleged deficient practice and has successfully discharged to home. #65: Resident's record was reviewed. Documentation shows resident did have bowel movements on 4/13/15 and 4/14/15. Resident displayed no negative outcomes from the alleged deficient practice. Resident continues to thrive in long term care setting. How other Residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken? All residents have the potential to be affected by this alleged deficient practice. A record review for all residents' output was conducted. There were no resident's displaying negative outcomes from the alleged deficient practice. A bowel and bladder performance program was already established and being reviewed during Quality Assurance Performance Improvement Program at the time of this survey event. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur? The Bowel and bladder policy was reviewed and found to be complete. Licensed nurses were re-educated on the Bowel and Bladder Policy. Nursing management will provide oversight for ongoing</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155198	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 05/28/2015
--	---	---	---

NAME OF PROVIDER OR SUPPLIER MARQUETTE	STREET ADDRESS, CITY, STATE, ZIP CODE 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
	<p>A "Hospital Discharge Summary" with a discharge date 5/20/15, indicated the resident was hospitalized on 5/15/15, after a fall at the facility and she was admitted to the hospital for treatment of a urinary tract infection. The resident's discharge diagnoses included, but were not limited to, urinary obstruction, hemorrhagic cystitis, anemia and fecal impaction. Pertinent Studies included, but were not limited to, CT Scat of the abdomen and pelvis without contrast, which indicated there was a fecal impaction in the rectum. The course of her hospital stay included, but was not limited to,</p> <p>"...2. Urinary Obstruction: On initial admission, patient grimaced to palpation of the abdomen. Bladder scan revealed that she had approximately 1.7 liters of urine in her bladder. We placed a Foley catheter that drained closer to 2 liters of fluid. The patient also had frank hematuria following this. Suspected she bled due to over distention of the bladder. Her hemoglobin did acutely drop from 8.8 on admission down to 7.4. Due to the extremity dark color of urine as well as suspected rapid bleeding, she was given 1 unit of blood. Her hemoglobin the day of discharge was 7.8. Her urine was returning clear on the day of discharge and the Foley was discontinued. It is</p>		<p>management of the bowel and bladder protocol, and physician notification. In addition, bowel documentation, interventions and physician notification is being reviewed during morning clinical meeting. How the corrective action will be monitored to ensure the deficient practice will not recur? The DON or her licensed designee, is completing Quality Improvement audits of bowel documentation and physician notification. A random sample of 5% residents are being reviewed weekly x 4 weeks, then bi-weekly x2 months, then monthly x3 months. (Attachment HC-2)The results of all audits are being reported to the Quality Assurance Performance Improvement Committee monthly for additional recommendations as necessary. Compliance Date: 6/27/2015</p>	

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 05/28/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER MARQUETTE	STREET ADDRESS, CITY, STATE, ZIP CODE 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
	<p>suspected that she have an obstruction from a large fecal impaction that was about 11 cm on the CT Scan.</p> <p>3. Fecal Impaction. this was found on the CT scan as noted to be about 11 cm. We tried multiple enemas including tap water, soapsuds and Fleet's and we have also manually disimpacted her about 3 days in a row. There is still a small amount of stool in the rectum as far as we can tell, although it seems the majority of the impaction has resolved. Continue to follow this as an outpatient to ensure she is passing stools appropriately. I suspect this is why she developed a urinary obstruction...."</p> <p>3. The record for Resident #105 was reviewed on 5/27/15 at 5:30 p.m. Diagnoses included, but not limited to, generalized muscle weakness and constipation.</p> <p>The resident did not have BM's documented for the following days: 4/16/15 through 4/19/15 (4 days) 5/17/15 through 5/20/15 (4 days)</p> <p>No documentation was found in the resident's record to indicate the physician was notified she had not had a BM in over 3 days.</p>			

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 05/28/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER MARQUETTE	STREET ADDRESS, CITY, STATE, ZIP CODE 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
	<p>4. The record for Resident #115 was reviewed on 5/27/15 at 2:46 p.m. Diagnoses included, but were not limited to, debility, constipation, generalized pain, and generalized muscle weakness.</p> <p>The resident did not have BM's documented for the following days: 4/9/15 through 4/13/15 (5 days) 4/21/15 through 4/25/15 (5 days)</p> <p>No documentation was found in the resident's record to indicate the physician was notified she had not had a BM in over 3 days.</p> <p>During an interview on 5/28/15 at 11 a.m., the DON (Director of Nursing) indicated she did not have any information to provide, which indicated the resident had BM's or PRN laxative medication were administered after the resident went without BM's for 3 days during the time periods listed above.</p> <p>5. The record for Resident #136 was reviewed on 5/27/15 at 5:16 p.m. Diagnoses included, but were not limited to, debility, generalized muscle weakness, constipation, nausea with vomiting, kyphosis and chronic pain.</p> <p>The resident did not have BM's documented for the following days:</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155198	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 05/28/2015
--	---	---	---

NAME OF PROVIDER OR SUPPLIER MARQUETTE	STREET ADDRESS, CITY, STATE, ZIP CODE 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
	<p>5/12/15 through 5/22/15 (11 days)</p> <p>No documentation was found in the resident's record to indicate the physician was notified she had not had a BM in over 3 days.</p> <p>6. The record for Resident #192 was reviewed on 5/27/15 at 5:02 p.m. Diagnoses included, but were not limited to, constipation, generalized muscle weakness, debility and generalized pain.</p> <p>The resident did not have BM's documented for the following days: 5/3/15 through 5/6/15 (4 days) 5/12/15 through 5/16/15 (5 days) 5/20/15 through 5/24/15 (4 days)</p> <p>No documentation was found in the resident's record to indicate the physician was notified she had not had a BM in over 3 days.</p> <p>On 5/27/15 at 12:45 p.m., during interview, the DON indicated she was not sure if the physician was notified if Residents #12, #105, #115, #136 and #192 had BM's after 3 days during time the periods listed above, but she was having the ADON look for that information and she would provide whatever information she was able to locate.</p>			

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 05/28/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER MARQUETTE	STREET ADDRESS, CITY, STATE, ZIP CODE 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
	<p>On 5/28/15 at 4:35 p.m., the DON indicated she did not locate any information in the records, which indicated the physician had been notified regarding Residents #12, #105, #115, #136 and #192 going without a BM for 3 days.</p> <p>During an interview on 5/28/15 9:31 a.m., LPN #22 indicated the bowel protocol was the night shift pulled up the list of residents and if a resident had not had a BM in 3 days, that resident received a bowel assessment, which consisted of checking for distention of the abdomen and bowel sounds. She indicated the resident received Milk of Magnesia (a laxative medication) from the dayshift nurse, then if he or she did not have a BM by the end of dayshift, the evening nurse gave the resident a Duloclast suppository (a laxative medication). She indicated if there were no results by the end of the evening shift, then the nightshift nurse gave the resident an enema (a medication given rectally to help loosen the stool in the bowel). If the resident still had no results after the enema, then the physician was suppose to be notified.</p> <p>7. On 5/26/15 at 4:09 p.m., record review for Resident #65 was completed. Diagnoses included, but were not limited</p>			

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 05/28/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER MARQUETTE	STREET ADDRESS, CITY, STATE, ZIP CODE 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
	<p>to, neuropathy, arthritis, osteoporosis, anxiety disorder and constipation.</p> <p>The resident Elimination Records indicated the resident had no bowel movements on the following dates:</p> <p>March 2015 3/3/15 through 3/9/15 (7 days) 3/16/15 through 3/21/15 (6 days)</p> <p>April 2015 4/11/15 through 4/15/15 (4 days) 4/18/15 through 4/24/15 (7 days)</p> <p>The Medication Administration Record dated April 2015, indicated LPN #3 gave Milk of Magnesium (MOM) (a laxative medication) on 4/15/15, and there was no results. The resident had orders for Bisacodyl (a laxative medication) 10 milligrams as needed one time for constipation, but it had not been documented as given.</p> <p>The Medication Administration Record dated April 2015, indicated the resident received as needed medications for constipation: Milk of Magnesia on 4/1/15, with results, but no follow up available. She also received a Fleets enema (a medication given rectally to help loosen stool in the bowel) on 4/17/15. There was an order for Lactulose</p>			

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 05/28/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER MARQUETTE	STREET ADDRESS, CITY, STATE, ZIP CODE 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
	<p>(a laxative medication) (30 milliliters) as needed every two days for constipation. The documentation for these medications indicated none of them were given.</p> <p>May 2015 5/15/15 through 5/25/15 (11 days)</p> <p>The Medication Administration Record dated May 2015, indicated the resident received standing dose medication of Docusate Sodium two times daily through 5/18/15. The order was changed for Docusate Sodium 100 milligrams three times daily on 5/18/15. She also received Senna Laxative 8.6-50 mg (2 tablets) twice daily. The resident received 30 milliliters of Lactulose orally every two days starting 5/19/15.</p> <p>The Medication Administration Record dated May 2015, for as needed medications, indicated the resident received Milk of Magnesia on 5/23/15 at 8:15 a.m., and as of 5/23/15 at 9:15 a.m., was not effective. She also received MOM on 5/25/15 at 8:21 a.m. and had results at 9:21 a.m.</p> <p>The nurses notes dated 5/18/15 through 5/23/15, did not indicate the resident had a bowel movement (BM).</p> <p>As of the exit conference on 5/28/15 at</p>			

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 05/28/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER MARQUETTE	STREET ADDRESS, CITY, STATE, ZIP CODE 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 0282 SS=E Bldg. 00	<p>5:40 p.m., there was no other BM documentation provided.</p> <p>A current policy titled "In Service-Bowel Protocol" undated, provided by the DON on 5/27/15 at 2:57 p.m., indicated "Bowel Protocol: All residents are to have Physician orders for medications to treat constipation... On a daily basis a licensed nurse is to review the resident's bowel movements to ensure prompt intervention to prevent constipation. Every Bowel Movement is to be documented in the Clinical Record, including the size and character of the stool. Initiation of a bowel protocol is to be documented in the clinical record, and documentation should continue every shift until a BM occur... Notify MD [Medical Doctor] of Residents who have had no response to the Bowel Interventions from the previous day-implement New Orders if given...."</p> <p>3.1-5(a)(3)</p> <p>483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. Based on observation, interview and record review, the facility failed to ensure</p>	F 0282	F 282 483.20(k)(3)(ii) Services by Qualified Person per Care	06/27/2015

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155198	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 05/28/2015
--	---	---	---

NAME OF PROVIDER OR SUPPLIER MARQUETTE	STREET ADDRESS, CITY, STATE, ZIP CODE 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
	<p>physician orders and resident's plans of care were followed for medication administration and bowel monitoring for 6 of 27 resident's reviewed for following the plan of care. (Residents #6, #12, #105, #115, #136 and #192).</p> <p>Findings include:</p> <p>1. The record for Resident #6 was reviewed on 05-18-15 at 2:00 p.m. Diagnoses included but were not limited to, new onset atrial fibrillation, chronic obstructive disease, history of gastrointestinal bleeding, and a history of cardiopulmonary arrest with bradycardia and possible Congestive Heart Failure. These diagnoses remained current at the time of the record review.</p> <p>The resident had physician orders dated 03-26-15, for Azithromycin (an antibiotic medication) 250 mg (milligrams) daily - COPD (chronic obstructive pulmonary disease).</p> <p>During an interview on 05-18-15 at 1:45 p.m., a concerned family member indicated, "I knew they missed the dose and the nurse said to me that maybe she could give mom two doses to make up the difference. She admitted to me that mom didn't get the full dose of the antibiotic. I talked to the Director of</p>		<p>Plan What corrective actions will be accomplished for those residents found to have been affected by the deficient practice? #6: Resident no longer resides in facility. Resident did not meet the definition of true infection following McGeers definitions. Resident displayed no negative outcomes from the alleged deficient practice. Resident has successfully discharged to assisted living facility. #12: Resident no longer resides at the facility. Resident displayed no negative outcomes from the alleged deficient practice. #105: Resident no longer resides in facility. Resident displayed no negative outcomes from the alleged deficient practice. Resident has successfully discharged to home. #115: Resident's record was reviewed. Resident displayed no negative outcomes from the alleged deficient practice. Resident continues to thrive in long term care. #136: Resident no longer resides in facility. Resident displayed no negative outcomes from the alleged deficient practice. Resident has successfully discharged to home. #192: Resident no longer resides in facility. Resident displayed no negative outcomes from the alleged deficient practice. Resident has successfully discharged to home. How other Residents having the</p>	

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 05/28/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER MARQUETTE	STREET ADDRESS, CITY, STATE, ZIP CODE 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
	<p>Nurses and she told me to talk to the Unit Manager. I talked to the Unit Manager and she said she would take care of it."</p> <p>A review of the electronic medical record on 05-22-15 at 8:00 a.m., Licensed Nurse #1 indicated, "We did the 30 min. [minute] O2 [oxygen] checks on her because she was non-compliant and would take the O2 off. She would de-sat [de-saturated] quickly and that's why we sent her to the pulmonologist. He ordered the Antibiotic."</p> <p>LPN #1 verified the physician order was documented and the resident was started on the physician ordered antibiotic on 03-26-15, "It was the way the order was put into the computer. She got the loading dose of 500 mg and did not receive the evening dose of 250 mg, but the computer counted the evening dose of the 250 mg as day one of the four days for the dosage of 250 mg."</p> <p>Surveyor: Nolder, Sandra 2. The record for Resident #12 was reviewed on 5/22/15 at 1:06 p.m. Diagnoses included, but were not limited to, fecal impaction, urinary obstruction, hematemesis, hemorrhagic cystitis, and anemia .</p>		<p>potential to be affected by the same deficient practice will be identified and what corrective action will be taken? All residents have the potential to be affected by the alleged deficient practice. All residents' bowel patterns have been reviewed. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur? Marquette has a policy regarding following physician orders and care plans. This policy was reviewed and found to be complete. licensed nurses were re-educated on the bowel and bladder policy and protocol, as well as following physician orders and care plans. Nurse managers are providing oversight of bowel monitoring and medication administration. How the corrective action will be monitored to ensure the deficient practice will not recur? The DON or licensed designee is completing Quality Improvement audits of bowel monitoring/medication administration . A random sample of 5% of resident are being reviewed weekly x 4 weeks, then bi-weekly x 2 months , then monthly thereafter. (Attachment HC-10) The results of all audits are being reported to the Quality Assurance Performance Improvement Committee monthly for additional recommendations</p>	

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 05/28/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER MARQUETTE	STREET ADDRESS, CITY, STATE, ZIP CODE 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
	<p>The resident's physician orders dated May 2015, included, but were not limited to, the following orders: 7/22/13--Milk of Magnesia (a laxative medication) 400 mg (milligrams) /5 ml (milliliters) (30 ml) by mouth as needed for constipation daily.</p> <p>The resident did not have BM's (bowel movement) documented for the following days: 5/8/15 through 5/15/15 (8 days)</p> <p>An "Elimination Record" provided by the Director of Nursing (DON) on 5/26/15 at 4:33 p.m., indicated for the following days 5/8/15 through 5/15/15, in the columns titled ER (Elimination Record) Bowel Consistency ER BM Size and ER BM Consistency, these areas had blank spaces for each of the following dates and times: 5/8/15 at 6:30 a.m. and 2:33 p.m. 5/9/15 at 2:18 p.m. and 10:16 p.m. 5/10/15 at 4:52 a.m., 10:55 a.m., 2:03 p.m. and 10:20 p.m. 5/11/15 at 3:25 p.m. and 9:16 p.m. 5/12/15 at 6:51 a.m., 1:55 p.m. and 10:21 p.m. 5/13/15 at 1:45 a.m., 2:27 p.m. and 2:10 p.m. 5/14/15 at 4:49 a.m., 10:57 a.m. and 4:01 p.m. 5/15/15 at 9:47 a.m. and 10:51 p.m.</p>		<p>as necessary. Compliance Date: 6/27/2015</p>	

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 05/28/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER MARQUETTE	STREET ADDRESS, CITY, STATE, ZIP CODE 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
	<p>The resident had a Care Plan dated 7/23/13, which addressed the problem she was at risk for constipation due to her aging process. Goal indicated: "I want to have a soft formed stool every 1-3 days thru the next review." Interventions included, "Document BMs in EMR [Electronic Medical Record] record and observe for changes in stool consistency and regularly. Notify MD and family of condition changes. Provide prn laxatives as ordered and document results. routine bowel meds as ordered."</p> <p>The record did not have any documentation to indicate PRN Laxatives were administered when she did not have a BM after 3 days.</p> <p>3. The record for Resident #105 was reviewed on 5/27/15 at 5:30 p.m. Diagnoses included, but were not limited to, generalized muscle weakness and constipation.</p> <p>The resident's Electronic Medication Administration Record (EMAR) dated May 2015, included, but were not limited to, the following orders: 4/16/15--Biscodyl 10 mg suppository rectally daily PRN for constipation. 4/16/15--Milk of Magnesia 400 mg/5 ml (30 ml) by mouth PRN daily for</p>			

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 05/28/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER MARQUETTE	STREET ADDRESS, CITY, STATE, ZIP CODE 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
	<p>constipation.</p> <p>The resident did not have BM's documented for the following days: 4/16/15 through 4/19/15 (4 days) 5/17/15 through 5/20/15 (4 days)</p> <p>An "Elimination Record" provided by the DON on 5/27/15 at 9:18 a.m., indicated in the for the following days 4/16/15 through 4/19/15 and 5/17/15 through 5/20/15, in the columns titled ER (Elimination Record) Bowel Consistency ER BM Size and ER BM Consistency, these areas had blank spaces for each of the following dates and times: 4/16/15 at 10:05 p.m. 4/17/15 at 4:37 a.m., 9:17 a.m., 1:14 p.m. and 7:28 p.m. 4/18/15 at 3:55 a.m., 8:25 a.m., and 10:00 p.m. 4/19/15 at 1:29 a.m., 10:00 a.m., 4:17 p.m. and 10:31 p.m.</p> <p>5/17/15 at 2:24 a.m., 10:21 a.m., 12:29 p.m., 3:06 p.m. and 9:34 p.m. 5/18/15 at 9:18 a.m., 3:20 p.m. and 10:25 p.m. 5/19/15 at 3:46 a.m., 10:03 p.m., 1:57 p.m. and 3:42 p.m. and 9:20 p.m. 5/20/15 at 3:27 a.m.</p> <p>Resident #105 's record lacked documentation to indicate PRN laxatives</p>			

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 05/28/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER MARQUETTE	STREET ADDRESS, CITY, STATE, ZIP CODE 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
	<p>were administered when she went without a BM for longer than 3 days.</p> <p>4. The record for Resident #115 was reviewed on 5/27/15 at 2:46 p.m. Diagnoses included, but were not limited to, debility, constipation, generalized pain, and generalized muscle weakness.</p> <p>The resident's Electronic Medication Administration Record (EMAR) dated May 2015, included, but were not limited to, the following orders: 10/16/13--Dulcolax Suppository 10 mg rectally PRN every 3 days for constipation 10/16/13--Docusate Sodium 100 mg by mouth PRN daily for constipation 10/16/13--Milk of Magnesia mint 400 mg/5 ml (30 ml) by mouth PRN every 3 days for constipation</p> <p>The resident did not have BM's documented for the following days: 4/9/15 through 4/13/15 (5 days) 4/21/15 through 4/25/15 (5 days)</p> <p>An "Elimination Record" provided by the DON on 5/27/15 at 6:25 p.m., indicated in the for the following days 4/9/15 through 4/13/15 and 4/21/15 through 4/25/15, in the columns titled ER (Elimination Record) Bowel Consistency ER BM Size and ER BM Consistency,</p>			

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 05/28/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER MARQUETTE	STREET ADDRESS, CITY, STATE, ZIP CODE 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
	<p>these areas had blank spaces for each of the following dates and times: 4/9/15 at 12:10 a.m. and 2:23 p.m. 4/10/15 at 3:37 a.m., 9:15 a.m., 12:07 p.m., 1:34 p.m. and 9:18 p.m. 4/11/15 at 10:41 p.m. and 7:46 p.m. 4/12/15 at 4:45 a.m., 10:33 a.m., 11:34 a.m., 2:20 p.m. and 4:42 p.m. 4/13/15 at 4:46 a.m., 9:36 a.m., 4:22 a.m. and 9:14 p.m.</p> <p>4/21/15 at 2:06 a.m., 7:32 a.m., 2:00 p.m. and 9:16 p.m. 4/22/15 at 2:01 a.m., 9:42 a.m. 2:49 p.m. and 8:28 p.m. 4/23/15 at 3:20 a.m., 10:41 a.m., 1:42 p.m., 4:30 p.m. and 9:25 p.m. 4/24/15 at 2:27 a.m., 10:11 a.m., 10:12 a.m., 12:50 p.m. and 8:23 p.m. 4/25 /15 at 6:19 a.m., 2:13 p.m. and 9:47 p.m.</p> <p>The resident had a Care Plan dated 7/23/15, which addressed the problem she was at risk for constipation due to her low physical activity. Goal: "7/23/15--I want to have a soft formed stool every 1-3 days thru the next review." Interventions included, "7/23/15- -Document BM's in EMR and observe for changes in her stool consistency and regularly. Administer bowel medications ordered... Consult with MD if she develops constipation."</p>			

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 05/28/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER MARQUETTE	STREET ADDRESS, CITY, STATE, ZIP CODE 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
	<p>During an interview on 5/28/15 at 11 a.m., the DON indicated she did not have any information to provide, which indicated the resident had BM's or received PRN laxative medications when she went without a BM for longer than 3 days, during the time periods listed above.</p> <p>5. The record for Resident #136 was reviewed on 5/27/15 at 5:16 p.m. Diagnoses included, but were not limited to, debility, generalized muscle weakness, constipation, nausea with vomiting, kyphosis and chronic pain.</p> <p>The resident's EMAR dated May 2015, included, but were not limited to, the following orders: 5/6/15--Bisacodyl 10 mg suppository rectally as needed daily for constipation 5/6/15--Milk of Magnesia 400 mg/5 ml (30 ml) daily PRN by mouth for constipation. 5/6/15--Docusate Sodium-Senna (stool softener) 8.6-50 mg 1 tablet PRN twice daily for constipation.</p> <p>The resident did not have BM's documented for the following days: 5/12/15 through 5/26/15 (15 days)</p>			

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 05/28/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER MARQUETTE	STREET ADDRESS, CITY, STATE, ZIP CODE 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
	<p>An "Elimination Record" provided by the DON on 5/27/15 at 9:18 a.m., indicated in the for the following days 5/12/15 through 5/26/15, in the columns titled ER (Elimination Record) Bowel Consistency ER BM Size and ER BM Consistency, these areas had blank spaces for each of the following dates and times:</p> <p>5/12/15 at 3:32 a.m., 6:24 a.m., 1:18 p.m., 4:36 p.m. and 10:07 p.m. 5/13/15 at 2:56 a.m., 10:07 a.m., 2:25 p.m. and 8:12 p.m. 5/14/15 at 4:21 a.m., 10:03 a.m., 3:59 p.m. and 8:05 p.m. 5/15/15 at 4:38 a.m., 10:04 a.m., 11:59 a.m., and 10:47 p.m. 5/16/15 at 2:00 a.m., 10:16 a.m., 4:20 p.m. and 7:27 p.m. 5/17/15 at 2:25 a.m., 10:27 a.m., 3:54 p.m. and 9:54 p.m. 5/18/15 at 4:40 a.m., 7:15 a.m., 1:56 p.m. and 10:09 p.m. 5/19/15 at 3:44 a.m., 8:59 a.m., 2:07 p.m. and 9:30 p.m. 5/20/15 at 1:18 a.m., 9:23 a.m., 4:15 p.m. and 8:37 p.m. 5/21/15 at 2:17 a.m., 10:58 a.m., 2:32 p.m. and 10:42 p.m. 5/22/15 at 3:15 a.m., 10:32 a.m., 3:59 p.m. and 9:29 p.m. 5/23/15 at 2:27 a.m., 10:41 a.m., 2:06 p.m. and 8:29 p.m. 5/24/15 at 9:01 a.m., 12:38 p.m. and 10:04 p.m.</p>			

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 05/28/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER MARQUETTE	STREET ADDRESS, CITY, STATE, ZIP CODE 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
	<p>5/25/15 at 2:16 a.m., 10:04 a.m., 3:31 p.m. and 10:04 p.m. 5/26/15 at 3:29 a.m., 9:58 a.m. and 3:28 p.m.</p> <p>The resident had a Care Plan dated 5/14/15, which addressed the problem of constipation related to limited mobility, new environment and recent procedure. Goal: "I wish to have a bowel movement at minimum of every 3 days." Interventions included, "Bowel medications as ordered... Observe for changes in bowel patterns and notify MD as indicated."</p> <p>On 5/27/15 at 12:24 p.m., the ADON provided information on a "BM Tracking Form", which indicated the resident was administered Milk of Magnesia on the following dates: 5/15/15--no results were documented 5/22/15--no results were documented 5/23/15--the resident had a BM on 5/23/15</p> <p>On 5/27/15 at 12:24 p.m., the ADON provided a partial copy of Resident #136's EMAR dated April 2015, with the following medications which included, but were not limited to the following: 5/6/15--Milk of Magnesia 400 mg/5 ml (30 ml) daily PRN by mouth for constipation. At that time, during</p>			

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 05/28/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER MARQUETTE	STREET ADDRESS, CITY, STATE, ZIP CODE 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
	<p>interview, the ADON indicated the information he provided was all the information he had on the resident's BM's and any PRN laxatives she may have been given.</p> <p>6. The record for Resident #192 was reviewed on 5/27/15 at 5:02 p.m. Diagnoses included, but were not limited to, constipation, generalized muscle weakness, debility and generalized pain.</p> <p>The resident's EMAR dated May 2015, included, but were not limited to, the following orders: 5/1/15--Biscodyl 10 mg suppository rectally PRN every day for constipation. 5/1/15-- Milk of Magnesia 400 mg/5 ml (30 ml) suspension by mouth PRN daily for constipation. 5/4/15--Senna 8.6 mg by mouth twice daily PRN for constipation.</p> <p>The resident did not have BM's documented for the following days: 5/3/15 through 5/6/15 (4 days) 5/12/15 through 5/16/15 (5 days) 5/20/15 through 5/24/15 (5 days)</p> <p>An "Elimination Record" provided by the DON on 5/27/15 at 9:18 a.m., indicated in the for the following days 5/3/15 through 5/6/15, 5/12/15 through 5/16/15 and 5/20/15 through 5/24/15 in the</p>			

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 05/28/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER MARQUETTE	STREET ADDRESS, CITY, STATE, ZIP CODE 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
	<p>columns titled ER (Elimination Record) Bowel Consistency ER BM Size and ER BM Consistency, these areas had blank spaces for each of the following dates and times:</p> <p>5/3/15 at 7:45 a.m., 2:19 p.m. and 7:00 p.m.</p> <p>5/4/15 at 4:35 a.m., 4:48 a.m., 10:50 a.m., 4:17 p.m. and 8:07 p.m.</p> <p>5/5/15 at 3:54 a.m., 9:49 a.m., 3:48 p.m. and 7:37 p.m.</p> <p>5/6/15 at 9:13 a.m., 11:34 a.m. and 8:48 p.m.</p> <p>5/12/15 at 4:08 a.m., 6:40 a.m., 1:29 p.m., 4:29 a.m. and 8:46 p.m.</p> <p>5/13/15 at 7:31 a.m., 3:57 p.m. and 7:11 p.m.</p> <p>5/14/15 at 3:16 a.m., 9:29 a.m., 1:32 a.m. and 7:25 p.m.</p> <p>5/15/15 at 9:48 a.m., 11:58 a.m., 4:04 p.m. and 8:42 p.m.</p> <p>5/16/15 at 2:02 a.m., 9:02 a.m., 3:43 p.m. and 7:11 p.m.</p> <p>5/20/15 at 3:26 a.m., 10:29 a.m., 12:59 p.m. and 8:19 p.m.</p> <p>5/21/15 at 2:23 a.m., 9:22 a.m., 2:42 p.m. and 2:32 p.m.</p> <p>5/22/15 at 3:23 a.m., 7:35 a.m., 4:21 p.m. and 8:38 p.m.</p> <p>5/23/15 at 2:03 a.m., 9:35 a.m., 4:10 p.m. and 8:18 p.m.</p> <p>5/24/15 at 10:31 a.m., 3:49 p.m. and 8:56</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155198	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 05/28/2015
--	---	---	---

NAME OF PROVIDER OR SUPPLIER MARQUETTE	STREET ADDRESS, CITY, STATE, ZIP CODE 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
	<p>p.m.</p> <p>The resident had a Care Plan dated 5/8/15, she was at risk for constipation due to limited mobility and change of environment.</p> <p>Goal: "I want to have a bowel movement at least every 3 days." Interventions included, "Bowel medications as ordered, notify md (physician) of ineffectiveness as needed. Encourage activity as tolerated."</p> <p>On 5/27/15 at 12:24 p.m., the ADON provided a partial copy of Resident #192's EMAR dated May 2015, with the following medications which included, but were not limited to the following: 5/1/15--Biscodyl 10 mg suppository rectally PRN every day for constipation. 5/1/15-- Milk of Magnesia 400 mg/5 ml (30 ml) suspension by mouth PRN daily for constipation.</p> <p>At that time, the ADON indicated the information he provided was all the information he had on the resident's BM's and any PRN laxatives she may have been given.</p> <p>During an interview on 5/27/15 10:06 a.m., the ADON (Assistant Director of Nursing) indicated a blank space on the "Elimination Record" for bowel consistency or size indicated Residents</p>			

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 05/28/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER MARQUETTE	STREET ADDRESS, CITY, STATE, ZIP CODE 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 0309 SS=G Bldg. 00	<p>#12, #105, #115, #136 and #192 did not have a BM for those shifts.</p> <p>3.1-35(g)(1)</p> <p>483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.</p> <p>Based on observation, interview and record review, the facility failed to ensure bowel movements (BM's) were monitored and assessments were completed for 7 of 9 residents reviewed for bowel monitoring. (Residents #12, #39, #105, #115, #136, #192, and #65). This deficit practice resulted in Resident #12 developing an 11 (cm) centimeter fecal impaction, which required 3 days to disimpact with multiple interventions and hospitalization. This deficit practice, also resulted in Resident #39 being hospitalized due to diarrhea stools with a diagnosis of acute short lived encephalopathy and dehydration from diarrhea.</p> <p>Findings include:</p>	F 0309	F 309 We respectfully request a face to face IDR F309. . Resident #39 had history of loose stools from her admission to Health Center on 1/26/15. Stools within the community were not diarrhea but described as loose. Per Bowel Protocol, physicians would not be notified until all steps of the protocol had been completed. While hospital diagnosis indicates dehydration, her labs then were unchanged from her admission labs. Resident # 12 had reported BM on 5/11/15, she was given MOM on day of discharge to the hospital. The fecal impaction listed was not diagnosed at the hospital until 5/18/15. Bowel protocol would expect first dose of laxative to be given on the fourth day, as is indicated with the residents identified. The EMR system utilized by Marquette	06/27/2015

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 05/28/2015	
NAME OF PROVIDER OR SUPPLIER MARQUETTE				STREET ADDRESS, CITY, STATE, ZIP CODE 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			
	<p>1. On 5/22/15 at 10:29 a.m., Resident #12 was observed sitting in her wheelchair in front of the nurses station holding the right of her abdominal area with her left hand and her head at the forehead area with her right hand. At that time, CNA #16 indicated to LPN #1 the resident had three soft BM's and her abdomen was hard. LPN #1 felt the resident's abdomen and asked if the resident was having any pain, but the resident did not respond verbally to LPN #1. The resident continued to guard her abdomen. LPN #1 indicated she was getting a stat KUB (Kidneys, Ureter and Bladder X-ray).</p> <p>On 5/22/15 at 10:45 a.m., a request was made to LPN #3 to have Resident #12 placed in bed and her abdomen assessed for bowel sounds as she was guarding her abdomen. LPN #3 and CNA #16 transferred the resident to bed. Resident #12 was partially laying on her left side with her bilateral legs bent up. LPN #3 attempted several times to have the resident roll onto her back and straighten out her legs, so she could assess her abdomen, but the resident stayed in the position she was laying in. LPN #3 listened to the resident's abdomen and palpated it, indicating she had hypoactive bowel sounds in the right lower quadrant</p>		<p>requires the user to enter a diagnosis for each medication entered. Constipation is the diagnosis coded for ay PRN or routine laxatives. F 309 483.25 Provide Care Services for Highest Well Being What corrective actions will be accomplished for those residents found to have been affected by the deficient practice? #12: Resident no longer resides at Marquette. Resident displayed no negative outcomes from the alleged deficient practice as evidence of clinical data. Records show the bowel protocol was implemented. The fecal impaction was not present at the time of hospital admission per hospital documentation and physician assessment. The fecal impaction was diagnosed after changes in abdominal assessment 3 days into hospital stay. Physician notes indicate fecal impaction in rectum possibly related to bladder distention/wall thickening associated with suspected cancer. Urinary obstruction was also not identified as problematic until 5/17/2015. An indwelling catheter was placed at that time. Family opted not to have further testing to identify prognosis. Resident transferred to hospice services on 5/19/2015 during hospital stay. Resident re-admitted to facility for ongoing management of end of life care. #39: Resident's record was reviewed. Record review showed</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155198	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____		X3) DATE SURVEY COMPLETED 05/28/2015
NAME OF PROVIDER OR SUPPLIER MARQUETTE			STREET ADDRESS, CITY, STATE, ZIP CODE 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	
	<p>(RLQ) and her abdomen was firm and distended. While LPN #3 was assessing the resident's abdomen, the resident placed her right hand over her right lower abdomen and had facial grimacing. At that time, LPN #3 asked her if she was having pain and Resident #12 indicated she was not having abdominal pain, but she continued to guard her right lower abdomen with facial grimacing. LPN #3 indicated the resident had a small amount of emesis last evening and only ate 10% for her breakfast this morning.</p> <p>On 5/22/15 at 12:45 p.m., LPN #3 and #4 went into the resident's room to assess the resident's stool due to a concern she had a black stool. LPN #3 and LPN #4 pulled the resident's brief down and a brown mushy colored stool was observed in her brief. LPN #3 indicated at that time, the resident's abdomen was harder now then it was earlier.</p> <p>The record for Resident #12 was reviewed on 5/22/15 at 1:06 p.m. Diagnoses included, but were not limited to, fecal impaction, advanced dementia, urinary obstruction, hematemesis, hemorrhagic cystitis, and anemia .</p> <p>The resident's physician orders dated May 2015, included, but were not limited to, the following orders:</p>		<p>bowel patterns were unchanged from time of admission until time of emergency room visit on 3/10/2015. Facility documentation shows resident had bowel movements on 3/1/15, 3/2/15, 3/3/15, and 3/4/15. Facility completed the hydration risk assessment; resident was not identified at risk for dehydration. Resident was sent to ER on 3/10/15 after an unresponsive episode. NP assessed Resident at the time of unresponsive episode; assessment documented in Progress note, including assessment of oral mucosa that displayed no signs/symptoms of dehydration. Resident was assessed in ER and sent back to the facility; no hospitalization required. Resident displayed no negative outcomes from the alleged deficient practice as evidence by clinical data. Resident's hospitalization was a result of an unrelated acute condition change with proper physician notification, assessment, and evaluation. Resident continues to thrive in long term care setting. #105: Resident no longer resides at Marquette. Review of records was conducted. Resident did not admit to facility until the evening of 4/16. Records show that this independent, continent Resident had no documented bowel movement x72 hours. Resident had a BM on day shift the following morning, therefore</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155198	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 05/28/2015
--	---	---	---

NAME OF PROVIDER OR SUPPLIER MARQUETTE	STREET ADDRESS, CITY, STATE, ZIP CODE 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
	<p>7/22/13--Milk of Magnesia (a laxative medication) 400 mg (milligrams) /5 ml (milliliters) (30 ml) by mouth as needed for constipation daily.</p> <p>The resident did not have BM's documented for the following days: 5/8/15 through 5/15/15 (8 days)</p> <p>No abdominal assessments were found documented for the days the resident did not have a BM.</p> <p>Resident #12's record lacked documentation to indicate PRN laxatives were administered when she went without a BM longer than 3 days.</p> <p>A Nursing progress note dated 5/16/15 at 4:56 a.m., indicated the resident was admitted to the hospital.</p> <p>A CT Scan of the Abdomen and Pelvis without contrast report dated 5/17/15, indicated, "...There is a very large amount of colonic stool distending the rectum to a diameter of 11 cm consistent with fecal impaction. There is additional stool present in the right colon along with moderate gaseous distention...."</p> <p>A "Hospital Discharge Summary" with a discharge date 5/20/15, indicated the resident was hospitalized on 5/15/15,</p>		<p>interventions were not needed, notification not indicated per policy. Records show that this Resident had no bowel movement from 5/17-5/20/2015. Resident discharged to home the morning of 5/20/2015, therefore interventions would not have been implemented, MD notification not indicated. Resident displayed no negative outcomes from the deficient practice and has successfully discharged to home. #115: Resident's record was reviewed, no interventions needed. Resident displayed no negative outcomes from the alleged deficient practice and continues to thrive in long term care setting. #136: Resident no longer resides in facility. Resident displayed no negative outcomes from the alleged deficient practice. Resident has successfully discharged to home. #192: Resident no longer resides in facility. Resident displayed no negative outcomes from the alleged deficient practice. Resident has successfully discharged to home. #65: Resident's record was reviewed, no interventions needed. Resident displayed no negative outcomes from the alleged deficient practice and continues to thrive in long term care setting.</p> <p>How other Residents having the potential to be affected by the same deficient practice will be identified and what</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155198	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 05/28/2015
--	---	---	---

NAME OF PROVIDER OR SUPPLIER MARQUETTE	STREET ADDRESS, CITY, STATE, ZIP CODE 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
	<p>after a fall at the facility and she was admitted to the hospital for treatment of a urinary tract infection. The resident's discharge diagnoses included, but were not limited to, urinary obstruction, hemorrhagic cystitis, anemia and fecal impaction. Pertinent Studies included, but were not limited to, CT Scat of the abdomen and pelvis without contrast, which indicated there was a fecal impaction in the rectum. The course of her hospital stay included, but was not limited to,</p> <p>"...2. Urinary Obstruction: On initial admission, patient grimaced to palpation of the abdomen. Bladder scan revealed that she had approximately 1.7 liters of urine in her bladder. We placed a Foley catheter that drained closer to 2 liters of fluid. The patient also had frank hematuria following this. Suspected she bled due to over distention of the bladder. Her hemoglobin did acutely drop from 8.8 on admission down to 7.4. Due to the extremity dark color of urine as well as suspected rapid bleeding, she was given 1 unit of blood. Her hemoglobin the day of discharge was 7.8. Her urine was returning clear on the day of discharge and the Foley was discontinued. It is suspected that she have an obstruction from a large fecal impaction that was about 11 cm on the CT Scan.</p>		<p>corrective action will be taken? All residents have the potential to be affected by the alleged deficient practice. All residents' bowel patterns have been reviewed. . A bowel and bladder performance program was already established and being reviewed during Quality Assurance Performance Improvement Program at the time of this survey visit. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur? The Bowel and bladder policy was reviewed and found to be completed. Licensed nurses were re-educated on the Bowel and Bladder Policy. Nursing management will provide oversight for ongoing management o the bowel and bladder protocol, and physician notification. In addition, bowel documentation, interventions and physician notification is being reviewed during morning meeting.</p> <p>How the corrective action will be monitored to ensure the deficient practice will not recur? The DON or licensed designee is completing Quality Improvement audits of bowel documentation. A random sample of 5% residents are being reviewed weekly x 4 weeks, then be-weekly x 2 months, then monthly x 3 months. Additional audits will be competed based upon the level of</p>	

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 05/28/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER MARQUETTE	STREET ADDRESS, CITY, STATE, ZIP CODE 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
	<p>...3. Fecal Impaction. this was found on the CT scan as noted to be about 11 cm. We tried multiple enemas including tap water, soapsuds and Fleet's and we have also manually disimpacted her about 3 days in a row. There is still a small amount of stool in the rectum as far as we can tell, although it seems the majority of the impaction has resolved. Continue to follow this as an outpatient to ensure she is passing stools appropriately. I suspect this is why she developed a urinary obstruction...."</p> <p>A KUB report dated 5/22/15, indicated "...There is evidence of a colonic ileus and constipation. Continued close clinical correlation is advised and follow-up would be warranted...."</p> <p>The resident's progress notes indicated the following: 5/20/15 at 11:15 p.m., indicated the resident was readmitted to the facility after hospitalization.</p> <p>5/21/15 at 6:15 p.m., indicated the resident had a moderate amount of dark brown emesis and a minimal amount of dark brown stool.</p> <p>5/22/15 at 10:49 a.m., indicated the doctor was notified of the resident's</p>		<p>compliance (Attachment HC-2) The results of all audits are being reported to the Quality Assurance Performance Improvement Committee monthly for additional recommendations as necessary. Compliance Date: 6/27/2015</p>	

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 05/28/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER MARQUETTE	STREET ADDRESS, CITY, STATE, ZIP CODE 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
	<p>abdominal pain, bloating and diarrhea. A new order for a KUB was given. The staff reported the resident had three episodes of loose stools and was restless and holding her abdomen. When her abdomen was assessed it was firm and tender to touch. The resident had not eaten any solid foods for breakfast.</p> <p>5/22/15 at 11:39 a.m., indicated the resident's bowel sounds were auscultated in all four quadrants and were hypoactive in the RLQ. The resident was guarding that area with facial grimacing while laying with limited extension of legs and partially laying on her left side. Her abdomen was firm and distended when palpated.</p> <p>5/22/15 at 1:37 p.m., indicated the KUB was completed. Resident #12 had one loose brown stool. Her bowel sounds were auscultated and was hypoactive. She was assisted up into her wheelchair by two staff members and was guarding her right side with her arm and leaning to the right.</p> <p>5/22/15 at 7:57 p.m., indicated the results of the KUB indicated the resident had a colonic ileus and constipation. The doctor was notified and a fleets enema was ordered now for constipation/ileus. The resident had hypoactive bowel</p>			

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 05/28/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER MARQUETTE	STREET ADDRESS, CITY, STATE, ZIP CODE 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
	<p>sounds and her appetite was poor. She refused staff feeding assistance.</p> <p>A late entry note dated 5/23/15 at 3:25 a.m., indicated two CNA's that had given care to the resident on 5/21/15 at 3:00 a.m., had reported the resident had an extra large amount of BM and brown colored emesis, which was foul smelling once at the same time as the BM.</p> <p>2. On 5/27/15 at 10:56 a.m. the record review for Resident #39 was completed. Diagnoses included, but were not limited to, dementia with delusions, depression, constipation, anemia and high blood pressure.</p> <p>The Elimination Record indicated the following: February 2015, the resident had from 1-3 softly formed or loose stools daily ranging from small to extra large. 3/1/15 through 3/4/15 (4 days)- there was no elimination documentation recorded. 3/5/15- Extra Large Loose bowel movement and a medium soft formed bowel movement. 3/6/15- Extra Large softly formed x 2, one Extra large loose and one small loose stool. 3/7/15- Extra Large soft formed stool 3/8/15- One medium loose stool. One Extra large and one large softly formed</p>			

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 05/28/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER MARQUETTE	STREET ADDRESS, CITY, STATE, ZIP CODE 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
	<p>stool.</p> <p>3/9/15- Extra Large softly formed stool.</p> <p>3/10/15- One medium softly formed stool and one extra large and one large loose stool.</p> <p>The Medication Administration Record dated February 2015, indicated the resident received Senna 8.6-50 milligrams daily (a medication to assist in bowel movement), daily during the time she was have loose stools.</p> <p>The resident was sent to the hospital on 3/11/15 after an episode of unresponsiveness, and the discharge summary indicated,"...Discharge Diagnoses 1. Acute short lived encephalopathy, most likely related to dehydration from diarrhea. 2. Syncopal episode. The patient hardly arousable, patient quite dehydrated. 3. Dehydration 4. Diarrhea, no stools since she has been here in the hospital...5. Acute kidney injury, Creatinine 1.6, now down to 1.1...8. Dementia...Observation Summary:... who was in her normal state of brain function before lunch yesterday when her grandson came back about 45 minutes later and found that she was not easily resposible[sic]...She was seen by a provider at [name of facility] who told the grandson that he saw no focal neuro findings, The patient had no focal neuro</p>			

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 05/28/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER MARQUETTE	STREET ADDRESS, CITY, STATE, ZIP CODE 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
	<p>findings when she came here, but was found to be quite dehydrated... patient felt much better with fluid hydration and had no further syncopal episode...."</p> <p>The nurses notes for February and March 2015, had no documentation regarding notification of physician regarding the frequency of loose stools.</p> <p>During interview on 5/28/15 at 12:39 p.m., the Director of Nursing (DON) indicated the resident had been given medication for the diarrhea.</p> <p>The Medication Administration Record for March indicated on 3/13/15, there were orders for Immodium (an antidiarrheal medication) 2 milligrams and an order dated 3/23/15, for Florastor (a probiotic medication to help balance GI system). These orders were post hospitalization. There were no other medications to help with diarrhea found in the documentation.</p> <p>3. The record for Resident #115 was reviewed on 5/27/15 at 2:46 p.m. Diagnoses included, but were not limited to, debility, constipation, generalized pain, and generalized muscle weakness.</p> <p>The resident's Electronic Medication Administration Record (EMAR) dated</p>			

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 05/28/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER MARQUETTE	STREET ADDRESS, CITY, STATE, ZIP CODE 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
	<p>May 2015, included, but were not limited to, the following orders: 10/16/13--Dulcolax Suppository 10 mg rectally PRN every 3 days for constipation 10/16/13--Docusate Sodium 100 mg by mouth PRN daily for constipation 10/16/13--Milk of Magnesia mint 400 mg/5 ml (30 ml) by mouth PRN every 3 days for constipation</p> <p>The resident did not have BM's documented for the following days: 4/9/15 through 4/13/15 (5 days) 4/21/15 through 4/25/15 (5 days)</p> <p>No abdominal assessments were found documented for the days the resident did not have a BM.</p> <p>Resident #115's record lacked documentation to indicate PRN laxatives were administered when she went without a BM for longer than 3 days.</p> <p>During an interview on 5/28/15 at 11 a.m., the DON indicated she did not have any information to provide, which indicated the resident had BM's or PRN laxative medication were administered after no BM for 3 days during the time periods listed above.</p> <p>4. The record for Resident #136 was</p>			

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 05/28/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER MARQUETTE	STREET ADDRESS, CITY, STATE, ZIP CODE 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
	<p>reviewed on 5/27/15 at 5:16 p.m. Diagnoses included, but were not limited to, debility, generalized muscle weakness, constipation, nausea with vomiting, kyphosis and chronic pain.</p> <p>The resident's EMAR dated May 2015, included, but were not limited to, the following orders: 5/6/15--Bisacodyl 10 mg suppository rectally as needed daily for constipation 5/6/15--Milk of Magnesia 400 mg/5 ml (30 ml) daily PRN by mouth for constipation. 5/6/15--Docusate Sodium-Senna (stool softener) 8.6-50 mg 1 tablet PRN twice daily for constipation. 5/7/15--Miralax (a laxative medication) 17 grams PRN daily starting 5/10/15 for constipation.</p> <p>The resident did not have BM's documented for the following days: 5/12/15 through 5/22/15 (11 days)</p> <p>No abdominal assessments were found documented for the days the resident did not have a BM.</p> <p>Resident #136's record lacked documentation to indicate PRN laxatives were administered when she went without a BM for longer than 3 days.</p>			

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 05/28/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER MARQUETTE	STREET ADDRESS, CITY, STATE, ZIP CODE 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
	<p>An admission "Nursing Evaluation" dated 5/6/15, indicated the resident's usual pattern of BM's were every two days.</p> <p>On 5/27/15 at 12:24 p.m., the ADON provided information on a "BM Tracking Form", which indicated the resident was administered Milk of Magnesia on the following dates: 5/15/15--no results were documented 5/22/15--no results were documented 5/23/15--the resident had a BM on 5/23/15</p> <p>On 5/27/15 at 12:24 p.m., the ADON provided a partial copy of Resident #105's EMAR dated April 2015, with the following medications which included, but were not limited to the following: 5/6/15--Milk of Magnesia 400 mg/5 ml (30 ml) daily PRN by mouth for constipation.</p> <p>At that time, the ADON indicated the information he provided was all the information he had on the resident's BM's and any PRN laxatives she may have been given.</p> <p>5. The record for Resident #192 was reviewed on 5/27/15 at 5:02 p.m. Diagnoses included, but were not limited to, constipation, generalized muscle weakness, debility and generalized pain.</p>			

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 05/28/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER MARQUETTE	STREET ADDRESS, CITY, STATE, ZIP CODE 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
	<p>The resident's EMAR dated May 2015, included, but were not limited to, the following orders:</p> <p>5/1/15--Biscodyl 10 mg suppository rectally PRN every day for constipation.</p> <p>5/1/15-- Milk of Magnesia 400 mg/5 ml (30 ml) suspension by mouth PRN daily for constipation.</p> <p>5/4/15--Senna 8.6 mg by mouth twice daily PRN for constipation.</p> <p>No abdominal assessments were found documented for the days the resident did not have a BM.</p> <p>Resident #192's record lacked documentation to indicate PRN laxatives were administered when she went without a BM for longer than 3 days.</p> <p>The resident did not have BM's documented for the following days: 5/3/15 through 5/6/15 (4 days) 5/12/15 through 5/16/15 (5 days) 5/20/15 through 5/24/15 (5 days)</p> <p>On 5/27/15 at 12:24 p.m., the ADON provided a partial copy of Resident #192's EMAR dated May 2015, with the following medications which included, but were not limited to the following: 5/1/15--Biscodyl 10 mg suppository rectally PRN every day for constipation.</p>			

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 05/28/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER MARQUETTE	STREET ADDRESS, CITY, STATE, ZIP CODE 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
	<p>5/1/15-- Milk of Magnesia 400 mg/5 ml (30 ml) suspension by mouth PRN daily for constipation.</p> <p>At that time, the ADON indicated the information he provided was all the information he had on the resident's BM's and any PRN laxatives she may have been given.</p> <p>6. On 5/26/15 at 4:09 p.m., record review for Resident #65 was completed. Diagnoses included, but were not limited to, neuropathy, arthritis, osteoporosis, anxiety disorder and constipation.</p> <p>The resident Elimination Records indicated the resident had no bowel movements on the following dates:</p> <p>March 2015 3/3/15 through 3/9/15 (7 days) 3/16/15 through 3/21/15 (6 days)</p> <p>April 2015 4/11/15 through 4/15/15 (4 days) 4/18/15 through 4/24/15 (7 days)</p> <p>The Medication Administration Record dated April 2015, indicated LPN #3 gave Milk of Magnesium (MOM) (a laxative medication) on 4/15/15 and there were no results. The resident had orders for Bisacodyl (a laxative medication) 10 milligrams as needed one time for</p>			

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 05/28/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER MARQUETTE	STREET ADDRESS, CITY, STATE, ZIP CODE 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
	<p>constipation, but it had not been documented as given.</p> <p>The Medication Administration Record dated April 2015, indicated the resident received as needed medications for constipation: Milk of Magnesia on 4/12/15, with results, but no follow up available. She also received a Fleets enema (a medication given rectally to help loosen stool in the bowel) on 4/17/15. There was an order for Lactulose (a laxative medication) (30 milliliters) as needed every two days for constipation. The documentation for these medications indicated none of them were given.</p> <p>May 2015 5/15/15 through 5/25/15 (11 days)</p> <p>The Medication Administration Record dated May 2015, indicated the resident received standing dose medication of Docusate Sodium two times daily through 5/18/15. The order was changed for Docusate Sodium 100 milligrams three times daily on 5/18/15. She also received Senna Laxative 8.6-50 mg (2 tablets) twice daily. The resident received 30 milliliters of Lactulose orally every two days starting 5/19/15.</p> <p>The Medication Administration Record dated May 2015, for as needed</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155198	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 05/28/2015
--	---	---	---

NAME OF PROVIDER OR SUPPLIER MARQUETTE	STREET ADDRESS, CITY, STATE, ZIP CODE 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
	<p>medications, indicated the resident received Milk of Magnesia on 5/23/15 at 8:15 a.m., and as of 5/23/15 at 9:15 a.m., was not effective. She also received MOM on 5/25/15 at 8:21 a.m., and had results at 9:21 a.m.</p> <p>The nurses notes dated 5/18/15 through 5/23/15, did not indicate the resident had a bowel movement (BM).</p> <p>As of the exit conference on 5/28/15 at 5:40 p.m., there was no other BM documentation provided.</p> <p>During an interview on 5/28/2015 at 9:23 a.m., CNA #21 indicated she documented the BM's on the electronic charting in the computer. She indicated she documented the BM's as often as the residents had a BM. She indicated she tried to document right after the resident had the BM because she was forgetful and she might forget the resident had the BM. She indicated if the resident did not have a BM for that shift she notified the nurse and she charted they did not have one in the electronic charting in the computer. She indicated in the electronic charting there was a place for stool, urine or stool and urine and a staff member was able to check what one type of toileting applied to the resident. She indicated if the staff member did not check the resident had a</p>			

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 05/28/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER MARQUETTE	STREET ADDRESS, CITY, STATE, ZIP CODE 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
	<p>BM for that shift, then there would be no documentation in the computer indicating the resident had a stool.</p> <p>During an interview on 5/28/15 9:31 a.m., LPN #22 indicated the bowel protocol was as follows: the night shift nurse pulled up the list of residents and if a resident had not had a BM in 3 days, that resident received a bowel assessment, which consisted of checking for distention of the abdomen and auscultating bowel sounds. She indicated the resident received Milk of Magnesia from the dayshift nurse, then if he or she had not had a BM by the end of dayshift, the evening nurse gave the resident a Duloclox suppository. She indicated if there were no results by the end of the evening shift, then the nightshift nurse gave the resident an enema. If the resident still had no results after the enema, then the physician was suppose to be notified. She indicated if a resident complained of constipation, nausea or vomiting, she would check to see if they had a BM and do a bowel assessment and look to see if he or she had a related diagnosis or a past history. She indicated if the symptoms were not relieved, then she would call the physician or give medications if the resident had medications ordered. If the resident had a diagnosis of dementia and had</p>			

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 05/28/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER MARQUETTE	STREET ADDRESS, CITY, STATE, ZIP CODE 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
	<p>abdominal distension or abdominal pain she would check to see if the resident had a BM, complete a bowel assessment, look for related diagnoses, give Milk of Magnesia and then notify the physician. She indicated what she did depended on whether or not the resident had a BM and what kind of symptoms the resident was displaying, because she might opt to call the physician first.</p> <p>A current policy titled "Change in Resident's Condition" dated 1/31/15, provided by the DON on 5/27/15 at 2:57 p.m., indicated "Policy Statement: [Name of facility] will notify the resident, his or her attending physician and responsible party of changes in the resident's medical/mental condition and/or status... Procedure:... Non-immediate Notification (Subacute) Problems:... Nursing Documentation: A. Any calls to or from physicians will be documented in the nurses notes indicating information conveyed or received... D. Acute and subacute problems are to be communicated shift to shift by verbal report and highlighting or discussing the problems listed on the 24 hour shift report to facilitate communication...."</p> <p>A current policy titled "In Service-Bowel Protocol" undated, provided by the DON</p>			

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 05/28/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER MARQUETTE	STREET ADDRESS, CITY, STATE, ZIP CODE 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
	<p>on 5/27/15 at 2:57 p.m., indicated "Bowel Protocol: All residents are to have Physician orders for medications to treat constipation... On a daily basis a licensed nurse is to review the resident's bowel movements to ensure prompt intervention to prevent constipation. Every Bowel Movement is to be documented in the Clinical Record, including the size and character of the stool. Initiation of a bowel protocol is to be documented in the clinical record, and documentation should continue every shift until a BM occurs.</p> <p>The Bowel intervention protocol should be completed according to the following schedule: Night Nurse: Review the BM report and list the names of the Residents who have had no BM for 3 days. List the names of the Residents who have had no response to the Bowel Interventions from the previous day. Turn the BM Tracking Form the previous day into the Unit Manager.</p> <p>Day Nurse: Assess Resident for need of MOM [Milk of Magnesia]... Notify MD [Medical Doctor] of Residents who have had no response to the Bowel Interventions from the previous day-implement New Orders if given. Administer MOM...</p> <p>Evening Nurse: Administer Suppository (per order) to any Residents with no response to the MOM...</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155198	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 05/28/2015
--	---	---	---

NAME OF PROVIDER OR SUPPLIER MARQUETTE	STREET ADDRESS, CITY, STATE, ZIP CODE 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 0323 SS=G Bldg. 00	<p>Aids: Aides are to record all BM's for every Resident on the clinical tracking form and to inform nurse if resident fails to have BM in a 3 day period...."</p> <p>3.1-37(a)</p> <p>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 observation, interview and record review, the facility failed to ensure fall prevention interventions were implemented and communicated to staff to prevent falls for 3 of 5 residents reviewed for accidents and supervision. (Residents #71, #12, and #48) . This deficient practice resulted in Resident #71 sustaining a right hip fracture requiring surgery to have the fracture stabilized. This deficit practice also resulted in Resident #12 sustaining facial abrasions and bruising with the largest measurement being 7.0 cm (centimeters) x 5.6 cm with a visit to the emergency room.</p> <p>Findings include:</p>	F 0323	F 323 We respectfully request a face to face IDR for F 323. For Resident #12, closed head trauma, while on the potential problem list of the ER, was ruled out by CT scan. Neuro-checks remained WNL prior to her hospitalization, no Mental Status changes were observed prior to hospitalization. Resident was end stage Alzheimer's disease and progressive decline, as is expected with the disease process was occurring. Resident #71 was no longer considered dependent, as his NWB status had been upgraded prior to his fall. Failure to identify exact height of bed and/or wheelchair, does not necessarily equate to poor unsafe care. Per policy, residents would have the surface	06/27/2015

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155198	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____		X3) DATE SURVEY COMPLETED 05/28/2015
NAME OF PROVIDER OR SUPPLIER MARQUETTE			STREET ADDRESS, CITY, STATE, ZIP CODE 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	
	<p>1. On 5/22/15 at 11:11 a.m., Resident #71 was observed laying in bed with a wedge pillow between his legs and an ace wrap from his right knee to his right hip. His right knee was edematous and had purple colored bruising. At that time, during interview CNA #23 indicated the resident returned from the hospital about a week ago because he fell and "broke" his hip and had to have surgery to repair it.</p> <p>The record for Resident #71 was reviewed on 5/26/15 at 10:29 a.m. Diagnoses included, but were not limited to, rehabilitation procedure, dementia with Lewy bodies, mood disorder, generalized pain, joint replacement hip, and fx (fractured) femur closed.</p> <p>A Quarterly MDS (Minimum Data Set) assessment dated 2/19/15, indicated the resident required extensive assist with one person physical assist for transfers and limited assist with one person physical assist to walk in his room or the corridors.</p> <p>The resident had a Care Plan dated 8/29/14, which addressed the problem he was at risk for falls due to he had impaired judgement of safety and a history of syncopal episodes, history of</p>		<p>to which they are transferring to, to be lower than the surface from which they are transferring. F 323 483.25 (h) Accidents What corrective actions will be accomplished for those residents found to have been affected by the deficient practice? #71: Resident's care plan and resident information sheet was reviewed and updated as needed. #12: Resident no longer resident in the facility. Closed head injury was ruled out upon hospital evaluation; neuro-checks remained within normal limits post fall. CT scans of head displayed no abnormal findings. #48: Resident's care plan and resident information sheet was reviewed and updated as needed. How other Residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken? All residents have the potential to be affected by the alleged deficient practice. All resident's fall risk scores, care plans and assignment sheets have been reviewed. A performance improvement plan was already initiated prior to annual survey, with the roll out of the New Fall Program presented at the ISDH 2015 Conference. Staff has been educated on fall program. What measures will be put into place or what systemic changes will</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155198		X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____		X3) DATE SURVEY COMPLETED 05/28/2015	
NAME OF PROVIDER OR SUPPLIER MARQUETTE				STREET ADDRESS, CITY, STATE, ZIP CODE 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			
	<p>falls and a fall with a fracture. Interventions included, but were not limited to, "... Ensure he is wearing proper footwear while out of bed... 3/8/15--Non-skid socks while in bed. All nursing staff education provided on appropriate criteria for low bed usage, 4/30/15--Ensure room is appropriate temperature... low bed."</p> <p>The resident's progress notes indicated the following regarding his falls: 3/15/15 at 12:46 p.m., indicated the resident was witnessed standing at the nurses station and attempted to pivot and turn and fell on his right side. He received a skin tear to his right elbow that measured 0.4 x 1.2 cm. He had AROM (active range of motion) to all extremities but complained of soreness to his right side. He was able to stand without added discomfort. He lifted his bilateral knees.</p> <p>3/17/15 at 3:46 p.m., indicated "IDT review for fall... Witnessed fall occurred on 3/15/15 at 1255 p.m.. Resident was observed at the nurses station attempting to pivot and turn when he lost his balance and fell on his right side. Resident unable to explain what he was attempting to do, where he was trying to go. Upon assessment. Resident noted to have a skin tear to right elbow, first aid performed to area. Root cause identified</p>		<p>be made to ensure that the deficient practice does not recur? Nursing Staff education has been provided on the fall policy and protocol. The new fall program was initiated beginning May 6, 2015. Nurse managers will provide oversight to ensure the interventions are up to date and communicated with staff. How the corrective action will be monitored to ensure the deficient practice will not recur? The DON or licensed designee is competing fall audits weekly x 4 weeks, then bi-weekly x2 months, then monthly thereafter. (Attachment HC-4) In addition falls are reviewed during morning clinical meeting. The results of all audits are being reported to the Quality Assurance Performance Improvement Committee monthly for additional recommendations as necessary. Compliance Date: 6/27/2015</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155198	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 05/28/2015
--	---	---	---

NAME OF PROVIDER OR SUPPLIER MARQUETTE	STREET ADDRESS, CITY, STATE, ZIP CODE 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
	<p>as progressive decline w [with] /Lewy body dementia. Interventions: staff education provided on Lewy body dementia-decrease stimulation, specific factors that increase risk for falls (vision, physical declines, cognitive declines.)"</p> <p>A Staff Education document titled "Lewy Body Dementia In-Service" dated March 2015, indicated nursing staff were educated on Lewy Body by signing in for the in-service. A document titled "Lewy Body" indicated "...Interventions: Low stimulation areas, Frequent observations-anticipating needs...."</p> <p>3/17/15 at 2:41 p.m., the resident yelled out in pain, had facial grimacing and guarded his RLE (right lower extremity) when assisted with dressing. He was unable to bear weight to his RLE. He would not allow staff to perform PROM (passive range of motion) to the RLE.</p> <p>3/17/15 at 9:31 p.m., indicated the resident was unable to bear weight on his BLE (bilateral lower extremities) and required assist of two staff members with transfers. Upon assessment he moaned with slight squeeze of his right thigh and with transfers. An X-ray of the right hip, thigh and knee was negative for a fracture.</p>			

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 05/28/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER MARQUETTE	STREET ADDRESS, CITY, STATE, ZIP CODE 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
	<p>3/24/15 at 12:55 p.m., indicated the resident complained of pain when RLE moved and facial grimacing and guarding his right leg. There was faint yellowish bruising remained to his right thigh. He was assisted into his wheelchair with use of a Hoyer lift with staff assist of 4. A new order for a CT scan of the pelvis and right hip and right thigh and leg was received due to complaints of severe pain after a fall.</p> <p>3/26/15 at 11:35 p.m., the physician called and indicated the resident needed to go to the hospital ER.</p> <p>3/27/15 at 4:29 a.m., indicated the resident was taken to the hospital ER at 11:40 p.m. Results from CT scan indicated a comminuted fracture of the greater trochanter of the proximal femur was seen. The ER physician called the facility after assessing the resident and indicated there was nothing that could be done for the resident because it was a "non-surgical" injury. He was brought back to the facility at 3:00 a.m., with orders for non-weight bearing on the right side and to follow up with orthopedic doctor in 10-14 days for consultation.</p> <p>4/21/15 indicated a new order for weight bear on BLE as tolerated was received.</p>			

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 05/28/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER MARQUETTE	STREET ADDRESS, CITY, STATE, ZIP CODE 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
	<p>4/22/15 at 4:12 p.m., indicated the resident was found sitting beside his bed on his bottom with his legs extended out. The resident had on Ted hose at the time of the fall and no non-skid footwear. He was lying in bed prior to the fall.</p> <p>A Nursing Staff In-Service document titled "Low Bed Criteria" dated April 2015, indicated staff were educated for this in-service by signing in for the in-service. A document titled "Low Bed Criteria" indicated "We need to discuss the appropriate criteria for low bed (assessed and implemented by IDT [Interdisciplinary Team] mgmt [management] team)...1. resident has document "roll outs" of bed, multiple interventions have been attempted and failed, and the IDT [Interdisciplinary Team] mgmt [management] had determined the Fall goal has changed from preventing falls to preventing falls w [with] / injuries 2. resident is totally dependent and unable to initiate or assist with sit to stand/transfers AND is identified as fall risk for falls from bed. Problems w/Low Bed use, when not appropriate for specific resident. 1. Resident that is able to initiate/assist with sit to stand/transfers will continue to attempt to get out of bed (if desired). A low bed is almost a guaranteed fall, not</p>			

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 05/28/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER MARQUETTE	STREET ADDRESS, CITY, STATE, ZIP CODE 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
	<p>many of the geriatric population have the strength to stand independently from floor level. 2. Low beds are RESTRAINTS when not used in the appropriate way. If we are using low beds to prevent the resident from getting out of bed when they desire to get up, then we are restraining them. (It is more important to identify what the need is, why are they wanting to get out of bed (toileting, hunger, bored, restless...) and put interventions in place to ensure their needs are met. Where can staff find the information on if a resident should be in a low bed? 1. RIS [Resident Information Sheet] 2. Care Plan...."</p> <p>A document titled "Resident Information Sheet" dated 4/22/15, indicated staff was educated on this date regarding the resident's care information updates. The care sheet indicated the resident was extensive assist with two person physical assist for transfers and mobility, had a low bed, weight bear as tolerated and was not a fall risk.</p> <p>4/28/15 at 10:39 a.m., indicated "IDT fall review...Unwitnessed fall occurred on 4/22/15 at 310 p.m.. resident found sitting on the floor at bedside. Resident stated he was "having fun" and he was having a difficult time trying to stand and get out of bed. Resident did not have on</p>			

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 05/28/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER MARQUETTE	STREET ADDRESS, CITY, STATE, ZIP CODE 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
	<p>proper foot wear... Root cause identified as improper footwear, acute physical decline r/t [related/to] decreased mobility, bed not in correct position for transfers. (The resident's record nor the Resident Information Sheet indicated what the correct height of the bed was for the resident transfers were for this resident). Interventions: OT screen for transfers, w/c [wheelchair] mobility, keep bed at correct height for Resident. New w/c w [with] / anti-tippers, appropriate for Resident's height has been delivered."</p> <p>4/30/15 at 7:37 a.m., indicated the resident was on the floor at the bedside in his room at 3:45 a.m., He was sitting in a "praying like" position facing towards the bed on bent knees. The bed was in a lower position than what was noted for the resident, but not all the way to the floor. (The resident's record nor the Resident Information Sheet indicated what the correct height of the bed was for the resident transfers were for this resident). He indicated he needed cold air, but was not able to describe what he was doing. Superficial abrasions were noted to his bilateral knees measured 1.0 x 1.0 cm.</p> <p>5/3/14 at 4:00 a.m., indicated the resident was heard and found on the floor in the middle of the hallway at 2:00 a.m. The</p>			

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 05/28/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER MARQUETTE	STREET ADDRESS, CITY, STATE, ZIP CODE 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
	<p>staff heard a resident fall and ran to investigate to see who it was and found this resident calmly sitting on the floor with his legs crossed at the shins and his right lower extremity with an outer rotation. 911 was immediately called and he was transferred to the hospital for evaluation and treatment.</p> <p>5/5/15 at 11:02 a.m., indicated "IDT fall review... Unwitnessed fall occurred on 4/30/15 at 345 am. Resident found kneeling at bedside, in "praying position." Resident stated he needed "cold air..." Upon assessment, noted superficial abrasions to both knees. Root cause identified as bed not correct height for resident transfers. (The resident's record nor the Resident Information Sheet indicated what the correct height of the bed was for the resident transfers were for this resident) Interventions: Staff inservice provided on bed height, risk vs. benefits of low beds, ensure room is comfortable temperature for resident. Unwitnessed fall occurred on 5/3/15 at 2 am. Resident was found sitting in the middle of the hall. Resident had safely transferred self out of bed, and fell during ambulation more than 15 ft away from point of origin... Upon assessment , nurse noted external rotation or Rt [right] leg, Nurse dispatched EMT [Emergency Medical Technician] to transfer resident</p>			

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 05/28/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER MARQUETTE	STREET ADDRESS, CITY, STATE, ZIP CODE 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
	<p>to ER for eval [evaluation]... Root cause: Resident actively participating in therapy services, rebounding from recent change in condition. The more therapy resident receives, the more he attempts to transfer and ambulate independently. Interventions will be reassessed and revised as needed upon return."</p> <p>5/5/15 at 11:27 a.m., Social Service note indicated "...Daughter explained that residents condition currently is R [right] hip fracture and they are deciding with resident as a family if they will operate on hip or not due to risks of surgery explained by the doctor. Daughter states that doctor reported to her that even with surgery, resident likely would not walk again due to muscle atrophy. Today we discussed that we will have interventions in place upon residents return including possible room change closer to nurses station...."</p> <p>5/11/15 at 7:30 p.m., indicated the resident was readmitted to the facility from the hospital.</p> <p>A hospital "Discharge Summary" with a discharge date 5/3/15, indicated the admitting/discharge diagnoses included, but were not limited to, status post fall with right hip revision. The resident's hospital course included, but was not</p>			

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 05/28/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER MARQUETTE	STREET ADDRESS, CITY, STATE, ZIP CODE 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
	<p>limited to, right proximal femur fracture and he was status post right hip revision.</p> <p>During an interview on 5/27/15 at 3:31 p.m., LPN #1 indicated Resident #71 had a fractured femur in March 2015, which was inoperable. She indicated he was standing next to a medication cart and went to hand the nurse something he thought he was holding in his hand and he fell down. She indicated he was ambulating independently at that time. She indicated the last time he fell, he broke his hip because he ambulated out into the hall and fell. She indicated the staff was educated on low bed criteria. She indicated since the resident returned from the hospital he had not attempted stand or ambulate on his own at that time, due to his right hip pain, which was being treated with routine pain medication. She indicated if a resident can attempt to transfer and his or her bed was placed in the low position, then the facility restrained the resident. If the resident was able to initiate a stand, then the low bed was not to be placed in the very low position, due to this contributed to injuries when the resident fell.</p> <p>A current "Resident Information Sheet" provided by LPN #1 on 5/26/15 at 11 a.m., indicated Resident #71 had a low bed and transfers and mobility were</p>			

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 05/28/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER MARQUETTE	STREET ADDRESS, CITY, STATE, ZIP CODE 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
	<p>extensive assist from 2 staff members, weight bear as tolerated and he was not a fall risk.</p> <p>During an interview on 5/27/15 at 6:25 p.m., the Director of Nursing (DON) indicated when the resident fell and broke his hip the second time he had ambulated into the hallway, but he was not to be up ambulating independently.</p> <p>During an interview on 5/28/15 at 9:23 a.m., CNA #21 indicated she received the information regarding her residents' care on her Resident Care Information Sheet. She indicated if she needed to know the bed height for a resident she would look at her "Resident Information Sheet" to get that information. At that time, she looked at the "Resident Information Sheet" for residents #71 and indicated she could not find a safe transfer height listed on the sheet for these residents, so she would leave their beds in the lowest position the bed could be in.</p> <p>2. On 5/22/15 at 10:29 a.m., Resident #12 was sitting in her wheelchair in front of the nurses station. She was observed to have bruising surrounding her bilateral eyes, under her eyes extending onto the top of her forehead. She was observed to have an abrasion to the bridge of her nose and to the middle of her forehead. She</p>			

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 05/28/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER MARQUETTE	STREET ADDRESS, CITY, STATE, ZIP CODE 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
	<p>had bruising to her bilateral hands extending past her wrists.</p> <p>On 5/22/15 at 12:45 p.m., Resident #12 was observed laying on top of the blanket barefooted and her pants were pulled down around her ankles. She had a brief on. CNA #2, LPN #3 and LPN #4 came into the resident's room and LPN #3 and LPN #4 assessed the resident.</p> <p>On 05/22/2015 at 2:59 p.m., the resident was observed laying in bed barefooted.</p> <p>The record for Resident #12 was reviewed on 5/22/15 at 1:06 p.m. Diagnoses included, but were not limited to, fecal impaction, urinary obstruction, hematemesis, hemorrhagic cystitis, and anemia.</p> <p>The resident had a Care Plan dated 7/23/13, which addressed the problem she was at risk for a fall with injury due to unstable gait at times and forgetting to use her walker. She makes unsafe decisions at times. She has a diagnosis of degenerative joint disease and neuropathy and received routine analgesics. Interventions included, "... Ensure she is wearing proper shoe wear when out of bed, Keep pathways clear of clutter, Offer assist with toileting as scheduled, Refer to therapy if a decline in function is</p>			

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 05/28/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER MARQUETTE	STREET ADDRESS, CITY, STATE, ZIP CODE 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
	<p>noted. 9/21/13--Offer to assist with toileting and ADL's daily at 5 am, Observe for her becoming overly tired and encourage her to rest as needed. Encourage her participation in restorative program. 10/21/14--After meals, escort back to room, provide toileting and offer to lie her down in bed to rest... 4/29/15--Bed remote secured to bed. Staff coaching on care plan intervention in place for fall risk. Therapy screen for w/c positioning. Up for meals either in dining room or in stationary chair with supervision. fall mat. frequent checks. low bed. Recommend adding mattresses at bedside and room change."</p> <p>A current "Resident Information Sheet" (RIS) provided by LPN #1 on 5/26/15 at 11 a.m., indicated the resident was extensive assist with one person physical assist for transfers and mobility, she had a low bed, she was not to be left alone in her wheelchair, toilet upon rising, before and after meals, as needed and 5 a.m. if awake and she was a fall risk.</p> <p>The resident's progress notes and staff education indicated the following regarding her falls:</p> <p>2/16/15 at 2:18 p.m., the resident was found on the floor in her room by a housekeeper. She only had her socks on</p>			

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 05/28/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER MARQUETTE	STREET ADDRESS, CITY, STATE, ZIP CODE 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
	<p>when found, but her shoes were in front of her. The note indicated it appeared she was attempting to transfer herself from the w/c to bed.</p> <p>2/17/15 at 12:49 p.m., the resident had an order to start physical therapy for a change in condition to work with transfers and ambulation.</p> <p>2/17/15 at 12:14 p.m., indicated "IDT FALL REVIEW...Unwitnessed fall occurred on 2/16/15 at approximately 145 pm. Housekeeper found resident in the room on the floor. Resident was wearing socks, w [with] /shoes on the floor in front of her, appears resident was attempting to transfer self from the w/c [wheelchair] to bed... Root cause identified as improper footwear, non-compliance with safety interventions r/t [related to] cognition, therapy screen from transfers, interventions include: therapy screen for safety with transfers w/proper footwear, Sleeping Diary x 3 days. Careplan reviewed, interventions updated-d/c [discontinue] walker in reach, d/c walk to dine, and d/c RNP [Restorative Nursing Program] eating."</p> <p>4/25/15 at 7:35 a.m., indicated the resident was found by a CNA at her bedside on the floor. She had appeared to be getting up for the day.</p>			

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 05/28/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER MARQUETTE	STREET ADDRESS, CITY, STATE, ZIP CODE 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
	<p>A "One-On-One Education" document dated 4/27/15, indicated CNA #21 was given a teachable moment related to this resident falling due to her bed was in the low position and she was not gotten up at 5 a.m., and offered to be toileted and dressed, so she attempted to get herself up, which resulted in a fall. (The resident's record nor the Resident Information Sheet indicated what the correct height of the bed was for the resident transfers were for this resident). CNA #21 indicated the resident had her call light on and when she entered the resident's room, Resident #12 was on the floor.</p> <p>4/28/15 at 10:53 a.m., indicated "IDT [Interdisciplinary Team] fall review...Unwitnessed fall occurred on 4/25/15 at 615 am. Resident found sitting on the floor at bedside. Appeared resident attempted to get self out of bed. Resident was barefooted at the time of the fall... Root cause identified as improper bed height, preference for am care/toileting at 5 am not followed. Improper footwear, was barefooted. (The resident's record nor the Resident Information Sheet indicated what the correct height of the bed was for the resident transfers were for this resident). Interventions: Staff education on proper</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155198	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 05/28/2015
--	---	---	---

NAME OF PROVIDER OR SUPPLIER MARQUETTE	STREET ADDRESS, CITY, STATE, ZIP CODE 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
	<p>bed height, am care and toileting schedule for 5 am preference."</p> <p>4/29/15 at 9.30 p.m., indicated the resident was found on the floor next to her bed by a CNA. The bed was in a very low position.</p> <p>A Nursing Staff In-Service document titled "Low Bed Criteria" dated April 2015, indicated staff were educated for this in-service by signing in for the in-service. A document titled "Low Bed Criteria" indicated "We need to discuss the appropriate criteria for low bed (assessed and implemented by IDT [Interdisciplinary Team] mgmt [management] team)...1. resident has document "roll outs" of bed, multiple interventions have been attempted and failed, and the IDT [Interdisciplinary Team] mgmt [management] had determined the Fall goal has changed from preventing falls to preventing falls w [with] / injuries 2. resident is totally dependent and unable to initiate or assist with sit to stand/transfers AND is identified as fall risk for falls from bed. Problems w/Low Bed use, when not appropriate for specific resident. 1. Resident that is able to initiate/assist with sit to stand/transfers will continue to attempt to get out of bed (if desired). A low bed is almost a guaranteed fall, not</p>			

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 05/28/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER MARQUETTE	STREET ADDRESS, CITY, STATE, ZIP CODE 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
	<p>many of the geriatric population have the strength to stand independently from floor level. 2. Low beds are RESTRAINTS when not used in the appropriate way. If we are using low beds to prevent the resident from getting out of bed when they desire to get up, then we are restraining them. (It is more important to identify what the need is, why are they wanting to get out of bed (toileting, hunger, bored, restless...) and put interventions in place to ensure their needs are met. Where can staff find the information on if a resident should be in a low bed? 1. RIS [Resident Information Sheet] 2. Care Plan...."</p> <p>A "One-On-One Education" document dated 4/29/15, indicated CNA #24 was given a teachable moment regarding using her Resident Information Sheet at all times and the resident's bed was not to be in the low position.</p> <p>5/5/15 at 10:17 a.m., indicated "...Unwitnessed fall occurred on 4/29/15 at approximately 9 p.m. Resident found on the mat at the side of the low bed. Resident unable to verbalize what happened or where she was attempting to go when she was getting out of bed... Root cause identified as improper bed height for transfers. (The resident's record nor the Resident Information Sheet</p>			

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 05/28/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER MARQUETTE	STREET ADDRESS, CITY, STATE, ZIP CODE 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
	<p>indicated what the correct height of the bed was for the resident transfers were for this resident). Interventions: staff education provided on low bed appropriateness, risk versus benefits of low beds. Staff report independently. Maintenance refer-secure bed control remote to head board."</p> <p>5/15/15 at 10:39 p.m., indicated a CNA found resident laying on her right side on the floor with her knees flexed. The resident had complaints of pain when staff tried to assist her up. She was taken to the hospital by ambulance.</p> <p>5/16/15 at 4:56 a.m., indicated the resident was admitted to the hospital for a urinary tract infection and closed head injury.</p> <p>5/19/15 at 10:45 a.m., IDT fall review "...Unwitnessed fall occurred on 5/13/15 at approximately 715 p, Staff observed resident propelling self down hall, resident was noted to be leaning forward in w/c and fell to a prone position. Aide attempted to catch resident when she observed her falling out of w/c but was unable to reach her in time. Abrasion noted to mid-forehead and nose, bruise to forehead. Root cause identified as resident appeared tired and had poor positioning in w/c-leaning forward.</p>			

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 05/28/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER MARQUETTE	STREET ADDRESS, CITY, STATE, ZIP CODE 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
	<p>Intervention: Staff coaching r/t [related to] plan of care interventions in place, therapy screen for w/c positioning. Unwitnessed fall occurred on 5/15/15 at 5:15 pm. Resident found lying on her right side on the floor at bedside. Resident pants and brief was pulled down around legs. Resident had 1 shoe on, 1 shoe off and lying in bed. Resident stated she was attempting to get up. Noted Resident's w/c at the end of the bed. Upon assessment, noted pain with rt leg movement... Root cause identified as resident left in bed at supper time. Interventions: Up for meals in dining room or if request to stay in room, up in stationary chair, supervision w/meals in dining room or resident room."</p> <p>."A document titled "Official Employee Reprimand" dated 5/13/15, indicated CNA #24 failed to follow the resident's plan of care as it was outlined on her RIS, which resulted in her falling. According to her RIS, she was to be assisted from meals, toileted and offered and assisted to lay down. The document indicated continued practice of non compliance with any resident's plan of care would result in further disciplinary action.</p> <p>A "One-On-One Education" document dated 5/14/15, indicated CNA #24 was given a teachable moment regarding</p>			

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 05/28/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER MARQUETTE	STREET ADDRESS, CITY, STATE, ZIP CODE 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
	<p>interventions and Resident Information Sheets were to be followed to decrease injuries to residents,</p> <p>5/20/15 at 11:15 p.m., the resident was readmitted to the facility after hospitalization after a fall.</p> <p>An Admission "Nursing Evaluation" dated 5/20/15, indicated the resident had the following areas: Right Eye Bruise-greenish yellow measured 3.2 x 1.1 cm (centimeters) Left Head Bruise-greenish yellow measured 7 x 5.6 cm Medial Nose Abrasion measured 1.7 x 0.3 cm Medial Head Abrasion measured 0.8 x 0.6 cm Right Nose Bruise-Purple/blue measured 3.0 x 2.0 cm</p> <p>During an interview on 5/27/15 at 3:24 p.m., LPN #1 indicated Resident #12 was admitted to the hospital on 5/15/15, for a urinary tract infection and a closed head injury after a fall. She indicated she fell out of her wheelchair on 5/13/15, because she appeared to be tired and her plan of care indicated the staff was to observe her for tiredness and lay her down if tiredness was observed and the plan of care was not followed. She indicated the fall on 5/15/15, was due to an unassisted transfer</p>			

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 05/28/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER MARQUETTE	STREET ADDRESS, CITY, STATE, ZIP CODE 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
	<p>and the resident was capable of getting her wheelchair ready and transferring herself into her bed. She indicated the staff did not want her to do this, but she had unassisted transfers when staff could not catch her in time. She indicated she had skin tears from falls, but when she fell face forward was the first fall she had suffered a significant injury.</p> <p>During an interview on 5/28/15 at 9:23 a.m., CNA #21 indicated she received the information regarding her residents' care on her Resident Care Information Sheet. She indicated if she needed to know the bed height for a resident she would look at her "Resident Information Sheet" to get that information. At that time, she looked at the "Resident Information Sheet" for residents #12 and indicated she could not find a safe transfer height listed on the sheet for these residents, so she would leave their beds in the lowest position the bed could be in.</p> <p>3. On 5/22/15 at 11:21 a.m., Resident #48 was laying in a full size low bed with one mattress laying next to her bed.</p> <p>On 5/26/15 at 11:23 a.m., the resident was laying in her full size low bed with her one mattress on the floor laying next to her bed.</p>			

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 05/28/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER MARQUETTE	STREET ADDRESS, CITY, STATE, ZIP CODE 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
	<p>On 5/26/15 at 3:16 p.m., the resident was laying in the full size low bed with a mat next to her bed, but no mattresses were next to her bed.</p> <p>A current "Resident Information Sheet" provided by LPN #1 on 5/26/15 at 11 a.m., indicated the resident was extensive assist with two person physical assist for transfers and mobility, was to have two mattresses on the floor and she was a fall risk.</p> <p>The record for Resident #48 was reviewed on 5/22/15 at 4:27 p.m. Diagnoses included, but were limited to, osteoarthritis, peripheral vascular disease, and generalized pain.</p> <p>The resident's progress notes indicated the following regarding her falls.</p> <p>3/27/15 at 1:04 a.m., indicated the resident was found on the floor at her bedside on the mat on the floor, laying on her right side with her head facing the foot of the bed.</p> <p>3/31/15 at 12:24 p.m., indicated "IDT review for fall... Unwitnessed fall occurred on 3/27/15 at approximately 1210 am. Resident found lying on her back on the bedside mat with knees drawn up, rocking back and forth (normal</p>			

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 05/28/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER MARQUETTE	STREET ADDRESS, CITY, STATE, ZIP CODE 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
	<p>position for resident)... Staff report that resident repositions self frequently while in bed often found with head at the foot of the bed. Root cause of the fall identified as Frequent repositioning in twin size bed. Does not allow much wiggle room. Interventions: SS [Social Services] referral-asst [assist] w [with] / obtaining consent from family for a full size bed or bariatric size bed or trial full body pillow for comfort with positioning. Sleep diary x 3 days. Trial administering APAP [Tylenol] at HS [bedtime] x [times] 14 days to rule out the frequent repositioning r/t [related/to] discomfort. Family agreed to trial bariatric size mattress flush against the wall w/mattress @ [at] BS [bedside] for 2-3 weeks. Implement 15 min [minute] checks while in bed to observe for frequent repositioning, ensuring resident is in the center of the bed, try to allow Resident to awaken naturally in the am, instead of morning nap-trial activities (encourage walks, social gatherings, show and tell with personal pictures, music low stimulating areas if appears overstimulated.) continue w/afternoon nap between 2p-4p (approx 1 hour in length), HS around 9 pm or if resident exhibits signs of tiredness/lethargy Trial nighttime briefs."</p> <p>4/23/15 at 7:21 a.m., indicated the</p>			

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 05/28/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER MARQUETTE	STREET ADDRESS, CITY, STATE, ZIP CODE 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
	<p>resident was found on the mattress next to her bed with a blanket on her and she appeared to be asleep.</p> <p>4/28/15 at 10:49 a.m., indicated "IDT fall review...Unwitnessed fall occurred on 4/23/15 at approximately 630 am. Resident was found on the mattress at bedside w/blanket over her, sleeping... Root cause identified as restless sleeper, very mobile in bed. Interventions: mattress x 2 at bedside. Central supply referral to research vendors for a bed with a lower frame. Therapy referral recommendations for body pillow to aid w/comfort and positioning while in bed."</p> <p>During an interview on 5/26/15 at 3:19 p.m., CNA #25 indicated since Resident #48 had her bigger bed she did not need the two mattresses stacked next to her bed. She indicated she placed the gray flat mat next to her bed now like she used to do when the resident had the low bed before.</p> <p>During an interview on 5/26/15 at 3:36 p.m., LPN #1 looked at a "Resident Care Sheet" and indicated at that time, this resident was to have two mattresses stacked next to her bed. At that time, she went into the resident's room and informed CNA #25 the resident was to have two mattresses stacked next to her</p>			

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 05/28/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER MARQUETTE	STREET ADDRESS, CITY, STATE, ZIP CODE 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
	<p>bed and she was to use her resident care sheet to provide care for her residents.</p> <p>During an interview on 5/27/15 at 3:24 p.m., LPN #1 indicated the correct height of the bed for transfers for Residents #71 and #12 depended on each resident according to how tall they were. She indicated each resident was a different height, so when they stood up out of bed their low beds would need to be raised off the ground at a different height, but she was unable to indicate what height each of these residents beds were to be raised to off the floor.</p> <p>During an interview on 5/28/15 at 9:23 a.m., CNA #21 indicated she received the information regarding her residents' care on her Resident Care Information Sheet. She indicated if she needed to know the bed height for a resident she would look at her "Resident Information Sheet" to get that information. At that time, she looked at the "Resident Information Sheet" for residents #48 and indicated she could not find a safe transfer height listed on the sheet for these residents, so she would leave their beds in the lowest position the bed could be in.</p> <p>A current policy undated, titled "Fall Prevention and Management" provided by the DON on 5/27/15 on 11:45 a.m.,</p>			

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 05/28/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER MARQUETTE	STREET ADDRESS, CITY, STATE, ZIP CODE 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 0327 SS=G Bldg. 00	<p>indicated "Policy: It is the policy of [Name of facility] to ensure a safe environment with least restrictive measures while promoting the highest possible level of independence and quality of life... Admission: 8. CNA's will be made aware of residents at high risk for falls via CNA assignment sheet..."</p> <p>3.1-45(a)(1) 3.1-45(a)(2)</p> <p>483.25(j) SUFFICIENT FLUID TO MAINTAIN HYDRATION The facility must provide each resident with sufficient fluid intake to maintain proper hydration and health. Based on observation, interview and record review, the facility failed to provide interventions to maintain hydration for 2 of 3 residents reviewed for hydration. (Residents #39). This deficient practice resulted in Resident #39 being hospitalized with a diagnosis of acute short lived encephalopathy and dehydration from diarrhea.</p> <p>Findings include:</p> <p>1. On 5/27/15 at 10:56 a.m., the record</p>	F 0327	F 327 We respectfully request a face to face IDR for F 327. Resident # 39 has shown only slight changes in her labs since her admission. Labs indicated CKD III. Previously with labs very similar, resident did not display any altered mental status. While hospital documentation purports dehydration, labs do not substantiate this, nor did the assessment completed by the Nurse Practitioner immediately previous to the ER visit. Resident #113 had end stage Alzheimer's Disease. She does not have the	06/27/2015

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155198	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 05/28/2015
--	---	---	---

NAME OF PROVIDER OR SUPPLIER MARQUETTE	STREET ADDRESS, CITY, STATE, ZIP CODE 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
	<p>review for Resident #39 was completed. Diagnoses included, but were not limited to, dementia with delusions, depression, constipation, anemia and high blood pressure.</p> <p>The estimated amount of fluids the resident should receive daily are 2,280 milliliters of fluid a day.</p> <p>The lab values for the residents Creatinine and BUN (Blood Urea Nitrogen) as of 2/5/15, were at the high end of the normal value range. On 2/9/15, the resident's BUN level was 35 (range 7-25 mg/dL (milligrams/decaliter)) and Creatinine level was 1.5 (range 0.6-1.3 mg/dL).</p> <p>The Consumption Records dated February and March 2015, indicated the resident received less than 1500 milliliters of fluid daily.</p> <p>The Consumption Records indicated the following: 3/1/15- 840 milliliters of fluid were consumed 3/2/15- 1,060 milliliters of fluid were consumed 3/3/15-1,440 milliliters of fluid were consumed 3/4/15- 720 milliliters of fluid were consumed</p>		<p>diagnosis of ESRD/HD, CA,GI Bleed or Septicemia. The fluid amounts listed in the medical record are only those fluids given with meals. This does not include the water provided at bedside, the fluids administered with medications or the fluids given during activities. Neither of these residents had physicians orders or care plans for I&O which would require detailed intake records. Failure of the C.N.A.s to identify the exact amount of milliliters in each glasses does not necessarily constitute a failure to provide fluids. F 327 483.25 (j) Hydration What corrective actions will be accomplished for those residents found to have been affected by the deficient practice? #113: The identity of this Resident is questionable as the diagnosis shown on the 2567 does not meet the criteria of any Marquette resident. This is evidenced by the Resident census and condition report presented during annual review showing no residents receiving dialysis services. Review of the records for the resident indicated by number was completed. Documentation from admission, throughout medicare stay demonstrates that Resident was offered, encouraged even to take in more fluids. Facility trialed alternative food and fluids, speech therapy, occupational</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155198	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 05/28/2015
--	---	---	---

NAME OF PROVIDER OR SUPPLIER MARQUETTE	STREET ADDRESS, CITY, STATE, ZIP CODE 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
	<p>3/5/15- 1080 milliliters of fluid were consumed 3/6/15- 840 milliliters of fluid were consumed 3/7/15-240 milliliters of fluid were consumed 3/8/15-840 milliliters of fluid were consumed 3/9/15-1080 milliliters of fluid were consumed 3/10/15- 240 milliliters of fluid were consumed</p> <p>The Elimination Record indicated the following: February 2015, the resident had from 1-3 softly formed or loose stools daily ranging from small to extra large. 3/1/15 through 3/4/15 (4 days)- there was no elimination documentation recorded. 3/5/15- Extra Large Loose bowel movement and a medium soft formed bowel movement. 3/6/15- Extra Large softly formed x 2, one Extra large loose and one small loose stool. 3/7/15- Extra Large soft formed stool 3/8/15- One medium loose stool. One Extra large and one large softly formed stool. 3/9/15- Extra Large softly formed stool. 3/10/15- One medium softly formed stool and one extra large and one large loose stool.</p>		<p>therapy, restorative programs as well as family involvement. Resident admitted to hospice in April of 2015 for end stage dementia and failure to thrive. Facility continued to encourage adequate food and fluid intakes (approximately 4000ml of fluids offered daily between hydration refrigerator on the unit, bedside water pitcher, nutritional supplements, mealtime fluids, and activities). #39: Resident's record was reviewed. Facility completed the hydration risk assessment; resident was not identified at risk for dehydration. Resident's bowel patterns were unchanged from time resident was admitted through ER visit. Resident continued to display no diarrhea while in ER. Resident was assessed by nurse practitioner prior to transport to emergency room (ER), assessment demonstrated no clinical signs of dehydration upon assessment. Labs drawn in the ER confirmed chronic renal impairment with slightly elevated BUN and Creatinine levels, all electrolytes remained within normal limits. Resident was sent back to the facility; no hospitalization required. Labs prior to the ER visit as well as current lab values indicate Resident's baseline is the same as while in the hospital. Resident displayed no negative outcomes from the alleged deficient practice as evidence by clinical data.</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155198	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____		X3) DATE SURVEY COMPLETED 05/28/2015
NAME OF PROVIDER OR SUPPLIER MARQUETTE			STREET ADDRESS, CITY, STATE, ZIP CODE 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	
	<p>The nurses notes for February and March 2015 had no documentation regarding notification of physician regarding the frequency of loose stools. The resident had an episode of unresponsiveness on 3/11/15 which resulted in her being sent to the hospital.</p> <p>The resident was sent to the hospital on 3/11/15, and the discharge summary indicated,"...Discharge Diagnoses 1. Acute short lived encephalopathy, most likely related to dehydration from diarrhea. 2. Syncopal episode. The patient hardly arousable, patient quite dehydrated. 3. Dehydration 4. Diarrhea, no stools since she has been here in the hospital...5. Acute kidney injury, Creatinine 1.6, now down to 1.1...8. Dementia...Observation Summary:... who was in her normal state of brain function before lunch yesterday when her grandson came back about 45 minutes later and found that she was not easily resposible[sic]... She was seen by a provider at [name of facility] who told the grandson that he saw no focal neuro findings, The patient had no focal neuro findings when she came here, but was found to be quite dehydrated... patient felt much better with fluid hydration and had no further syncopal episode...."</p>		<p>Resident's hospitalization was a result of an unrelated acute condition change with proper physician notification, assessment, and evaluation. Resident is offered approximately 4700ml of fluids daily between hydration refrigerator on the unit, bedside water pitcher, nutritional supplements, mealtime fluids, and activities. Resident continues to thrive in long term care setting.</p> <p>How other Residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken? All residents have the potential to be affected by the alleged deficient practice. All residents' hydration risk scores have been reviewed and care plans updated if necessary. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur? Marquette has a policy regarding the management of hydration. The policy was reviewed and found to be compete. Nursing personnel were re-educated on the hydration policy and protocol. Nurse managers and registered dietician will provide oversight of the ongoing management of the hydration protocol. How the corrective action will be monitored to ensure the deficient practice will not recur? The DON or licensed</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155198	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 05/28/2015
--	---	---	---

NAME OF PROVIDER OR SUPPLIER MARQUETTE	STREET ADDRESS, CITY, STATE, ZIP CODE 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
	<p>On 5/28/15 at 12:39 p.m., the Director of Nursing (DON) was requested to provide any hydration interventions, any other physician orders or nursing measures to address potential for dehydration, after having frequent episodes of diarrhea and decreased fluid intake. As of the exit conference on 5/28/15 at 5:40 p.m., she indicated she had provided all the documentation she had for the resident.</p> <p>2. On 5/26/15 at 12:21 p.m., two different unidentified CNA's gave different answers for how many milliliters were in the different kinds of glasses observed in the dining room. There were tall skinny glasses, short fat glasses, short thin glasses, and coffee mugs observed on residents' trays in the dining room.</p> <p>On 05/28/15 at 9:47 a.m., CNA #26 indicated the CNA's document the monthly nutrition values for food and drinks in the Meal Consumption record book. She indicated they write how much was consumed at meals. She indicated in the residents' rooms they have 120 milliliter plastic cups and larger 240 milliliter plastic cups. She had to confirm with LPN #22 regarding the milliliters of the glasses. Also, CNA #26 talked to another unidentified CNA and the two of them indicated the newer</p>		<p>designee is conducting quality improvement audits of hydration. A random sample of 5% resident records are being reviewed weekly x 4 weeks, then bi-weekly x2 months, then monthly thereafter. (Attachment HC-5) The results of all audits are being reported to the Quality Assurance Performance Improvement Committee monthly for additional recommendations as necessary. Compliance Date: 6/27/2015</p>	

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 05/28/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER MARQUETTE	STREET ADDRESS, CITY, STATE, ZIP CODE 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 0328 SS=D Bldg. 00	<p>glasses on the table were 200 milliliters and the other unidentified CNA indicated they were 210 milliliters.</p> <p>3.1-46(b)</p> <p>483.25(k) TREATMENT/CARE FOR SPECIAL NEEDS The facility must ensure that residents receive proper treatment and care for the following special services: Injections; Parenteral and enteral fluids; Colostomy, ureterostomy, or ileostomy care; Tracheostomy care; Tracheal suctioning; Respiratory care; Foot care; and Prostheses.</p> <p>Based on observation, interview and record review, the facility failed to ensure a resident was monitored during a respiratory treatment for 1 of 3 residents reviewed for respiratory needs in a sample of 6. (Resident #7).</p> <p>Findings include:</p> <p>The record for Resident # 7 was reviewed on 05-22-15 at 2:30 p.m. Diagnoses included, but were not limited to, depression, dementia with behavior's, and chronic airway obstruction. These diagnoses remained current at the time of</p>	F 0328	<p>F 328 483.25 (k) Special Needs</p> <p>What corrective actions will be accomplished for those residents found to have been affected by the deficient practice? #7: Resident displayed no negative outcomes by the alleged deficient practice. Staff education with the licensed nurse was performed immediately. How other Residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken? All residents receiving respiratory</p>	06/27/2015

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155198	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____		X3) DATE SURVEY COMPLETED 05/28/2015
NAME OF PROVIDER OR SUPPLIER MARQUETTE			STREET ADDRESS, CITY, STATE, ZIP CODE 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	
	<p>the record review.</p> <p>The clinical record indicated the resident had physician orders for Ipratropium/Albuterol (a medication to aid in breathing) 0.5 mg (milligram) - 3 mg (2.5 mg base)/3 ml (1 vial) nebulizer COPD (chronic obstructive pulmonary disease) at 9:00 a.m., 1:00 p.m., 5:00 p.m. and 9:00 p.m.</p> <p>A review of the current plan of care, originally dated 04-29-14, indicated, "I have a potential risk to have a decline in my respiratory status due to my dx. [diagnosis] of COPD I am having increasing shortness of breath and require additional medications for a time period." Interventions included, "Assess respiratory status as indicated for changes in condition, notify MD [Medical Doctor]. Elevate head of bed as needed, Inform MD and family of changes in condition, observe for shortness of breath, dyspnea, administer respiratory medications as ordered."</p> <p>During an observation on 05-22-15 at 2:00 p.m., licensed nurse #3 was observed adjacent to the door to the resident's room. During this observation, the resident's privacy curtain was closed, obstructing the view of the nurse to observe the resident during the treatment.</p>		<p>treatments have the potential to be affected by the alleged deficient practice. Staff education on the Neb treatment/inhalation policy has been educated.</p> <p>What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur? Marquette has a policy regarding provision of respiratory therapy treatments. The policy was reviewed and found to be complete. Licensed nurses have been re-educated on the policy. All licensed nurses have completed a skills competency on the provision of nebulizer treatments. How the corrective action will be monitored to ensure the deficient practice will not recur? The DON or licensed designee is conducting a nebulizer treatment/inhalation audit weekly x 4 weeks, then bi-weekly x2 months, then monthly thereafter. (Attachment HC-6)The results of all audits are being reported to the Quality Assurance Performance Improvement Committee monthly for additional recommendations as necessary. Compliance Date: June 27, 2015</p>		

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 05/28/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER MARQUETTE	STREET ADDRESS, CITY, STATE, ZIP CODE 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
	<p>During an interview on 05-22-15 at 2:00 p.m., the licensed nurse indicated the resident was in the middle of her "breathing treatment."</p> <p>During a subsequent observation on 05-27-15 at 10:00 a.m., licensed nurse #8 started the scheduled breathing treatment. The licensed nurse entered the resident's room and then exited the resident room. The resident was left unattended with the breathing treatment.</p> <p>The LPN #1 was alerted and the LPN #1 came to the resident's room. The LPN #1 verified, the resident was left unattended, "but maybe [resident] is allowed to self medicate. I'll go check the record."</p> <p>LPN #1 left the resident unattended and checked the resident's chart at the nurses station. LPN #1 verified the resident did not have an order to self administer the breathing treatment.</p> <p>A review of the facility policy on 05-27-15 at 2:57 p.m., titled "Nebulizer Mist Inhalation Treatment," undated indicated the following:</p> <p>"Purpose: To deliver aerosolized medication into the lower respiratory tract. To aid in the removal of thick</p>			

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 05/28/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER MARQUETTE	STREET ADDRESS, CITY, STATE, ZIP CODE 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 0371 SS=F Bldg. 00	<p>secretions from the lower respiratory tract..."</p> <p>"Procedure:... 3. Assess breath sounds, rate, resident's color... 8. Instruct the resident or assist to: sit up straight as possible, hold the nebulizer up-right and close lips securely around the mouthpiece or adjust the mask - for maximum chest expansion. 9. Instruct resident to inhale deeply and hold for several seconds - requires alert and co-operative residents. 10. Remain with resident sufficiently long enough to ensure technique and use of all medication - all solution should be used... 15. Document procedure and resident's tolerance...."</p> <p>During an interview on 05-28-15 at 3:00 p.m., the Director of Nurses indicated she could not find documentation/assessment by the licensed nurse in regard to the resident prior to the treatment, or the resident's tolerance at the conclusion of the treatment.</p> <p>3.1-47(a)(6)</p> <p>483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155198	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 05/28/2015
--	---	---	---

NAME OF PROVIDER OR SUPPLIER MARQUETTE	STREET ADDRESS, CITY, STATE, ZIP CODE 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
	<p>local authorities; and</p> <p>(2) Store, prepare, distribute and serve food under sanitary conditions</p> <p>Based on observation, interview and record review, the facility failed to ensure the kitchen stored and prepared food under sanitary conditions for 1 of 1 kitchens. This deficient practice had the potential to effect 64 of 64 residents who received meals from the kitchen.</p> <p>Findings include:</p> <p>During the initial tour of the facility kitchen on 05-18-15 at 10:15 a.m., with the Food Service Supervisor and the Executive Chef in attendance the following was observed:</p> <p>5 of 5 pans identified by the Executive Chef as large braising had a black heavy build up of a black substance.</p> <p>2 of 3 "large pots" had a dark brownish build up with a chauky color identified as "hard water deposits" by the Executive Chef.</p> <p>1 of 3 coffee thermos' had a brown build up from the upper edge of the opening of the thermos to the bottom surface.</p> <p>The ice cream freezer had green spillage across the bottom.</p>	F 0371	<p>F 371 483.35 (I) Food Procure, Store/ Prepare Serve-Sanitary</p> <p>1. What corrective actions will be accomplished for those residents found to have been affected by the deficient practice: No specific resident was found to be affected by this practice. Marquette serves approximately 37,000 meals from main kitchen monthly with no ill effects registered. 2. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken; All residents being served from the main kitchen have the potential to be affected by this practice. Basil, Spinach and onions were thrown away in front of surveyor, although invoices indicate that the Spinach was purchased two days previously and the green onions were purchased three days earlier. Roasting pans were disposed of and new ones ordered. Pots identified were disposed of and new ones ordered. Coffee thermoses were cleaned. Muffin pans were disposed of and new ones purchased. Plant replaced gripper strips in the walk in cooler. Lids on the spices were closed during kitchen tour. Ice cream cooler was cleaned. 3. What measures will be put into</p>	06/27/2015

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155198	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 05/28/2015
--	---	---	---

NAME OF PROVIDER OR SUPPLIER MARQUETTE	STREET ADDRESS, CITY, STATE, ZIP CODE 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
	<p>1 of 3 muffin tins had a black build up of a burnt on substance.</p> <p>The threshold of the walk in cooler had pieces of gripper strips that were frayed and worn. The Executive Chef indicated the gripper strips needed to be replaced.</p> <p>The "Old Bay Spice," although dated was open.</p> <p>The "Ground Ginger," although dated was open.</p> <p>Refrigerator #2 had two plastic bags of "Basil" opened and undated. A bag of Spinach was opened and undated. The Green Onions were dated, but were not sealed.</p> <p>During this observation the Executive Chef indicated the items were to be dated and sealed when in the refrigerator.</p> <p>A review of the facility policy on 05-27-15 at 10:50 a.m., indicated the following:</p> <p>"Policy: It is the policy of the community to store foods under proper conditions of sanitation, temperature, light, moisture, ventilation and security."</p> <p>"Procedure: 1. Food storage areas shall</p>		<p>place or what systemic changes will be made to ensure that the deficient practice does not recur; As indicated in the survey report, Marquette has a policy regarding food storage and kitchen sanitation. Chefs and Cooks have been re-educated on items identified during the survey process. The Certified Dietary Manager will tour the kitchen with Chef and/ or Cooks, two times weekly for four weeks, then weekly thereafter, documenting findings. 4. How the corrective actions will be monitored to ensure the deficient practice will not recur, what quality assurance program will be put into place; The Certified Dietary Manager or designee is conducting quality improvement audits of the kitchen including weekly inspections. (Attachment HC-7) Results of the weekly inspections and all audits are being reported to the Quality Assurance Performance Improvement Committee monthly for additional recommendations as necessary. 5. Compliance Date: June 27, 2015</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155198	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 05/28/2015
--	---	---	---

NAME OF PROVIDER OR SUPPLIER MARQUETTE	STREET ADDRESS, CITY, STATE, ZIP CODE 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 0431 SS=D Bldg. 00	<p>be clean at all times... 14. Leftover foods are labeled, dated, immediately placed under refrigeration and used within 72 hours or discarded... 16. All exposed foods should be stored tightly covered."</p> <p>3.1-21(h)(3)</p> <p>483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS</p> <p>The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled.</p> <p>Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.</p> <p>In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.</p> <p>The facility must provide separately locked, permanently affixed compartments for</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155198	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 05/28/2015
--	---	---	---

NAME OF PROVIDER OR SUPPLIER MARQUETTE	STREET ADDRESS, CITY, STATE, ZIP CODE 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
	<p>storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.</p> <p>Based observation, interview and record review, the facility failed failed to properly label medications after an order change for 2 of 2 residents observed for direction change labels (Residents #65 and #130) and failed to ensure controlled medications were secured for 1 of 2 medication rooms.</p> <p>Findings include:</p> <p>During an observation on 05-24-15 at 7:45 a.m., licensed nurse #8 prepared medications for Resident #65. The nurse placed the medications into a plastic cup, which included Requip (a medication for restless legs) 2 mg (milligrams) one tablet. During this observation, the medication card provided from the pharmacy contained the following direction's: "2 mg - 1 tablet - to be taken at 6:00 a.m., 2 mg - one tablet to be taken at 10:00 a.m., 2 mg - 2 tablets - to be taken at 2:00 p.m., 2 mg - 4 tablets at 6:00 p.m. and 2 mg - 2 tablets at 10:00 p.m."</p>	F 0431	<p>F 431 483.60(b)(d)(e) Drug Records Label/Store Drugs and Biologicals What corrective actions will be accomplished for those residents found to have been affected by the deficient practice? #65: Resident displayed no negative outcome from the alleged deficient practice. Resident received the medication as ordered by physician. An order change sticker was applied to the medication label. #130: Resident displayed no negative outcome from the alleged deficient practice. Resident received the medication as ordered by physician. An order change sticker was immediately applied to the medication label. 1:1 education was provided to the nurse. How other Residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken? All residents have the potential to be affected by the alleged deficient practice. Medication cart audits have been completed to ensure current orders are consistent with pharmacy labels. What</p>	06/27/2015

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155198	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____		X3) DATE SURVEY COMPLETED 05/28/2015
NAME OF PROVIDER OR SUPPLIER MARQUETTE			STREET ADDRESS, CITY, STATE, ZIP CODE 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	
	<p>A reconciliation of the current physician orders for May 2015, indicated "Requip 2 mg two times a day and at 10:00 p.m. The medication card lacked a "change" label to alert the nurse.</p> <p>During a subsequent observation on 05-24-15 at 8:35 a.m., licensed nurse #8 prepared medication for Resident #130. The licensed nurse prepared all medications including Tylenol (an analgesic) 325 mg two tablets. The medication card prepared by the pharmacy indicated Tylenol 325 mg two tablets three times a day.</p> <p>A reconciliation of the resident's physician orders, dated 05-15-15 changed the administration to two times a day. The medication card lacked a "change" label to alert the nurse.</p> <p>During an observation on 05-20-15 at 9:00 a.m., with LPN #1 in attendance, the unlocked refrigerator in the locked medication room, contained a metal box. The Unit Manager removed the unlocked metal box from the refrigerator. The Unit Manager identified a medication in this box as Ativan (an anti-anxiety medication controlled substance).</p> <p>LPN #1 indicated, "This box is supposed to be locked."</p>		<p>measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur? As indicated in the survey report, Marquette has a policy regarding medications order changes. The policy was reviewed and found to be complete. Licensed nurses have been re-educated on the Drug label and storage policy. Nursing managers will provide oversight to ensure labels are updated with medication changes and controlled medications are secure. How the corrective action will be monitored to ensure the deficient practice will not recur? The DON or licensed designee is conducting quality improvement audits of medication labeling and storage. A random audit of 5% of residents will be checked weekly x 4 weeks, then bi-weekly x2 months, then monthly thereafter. (Attachment HC-8)The pharmacy consultant will assist with audits during routine visits. The results of all audits are being reported to the Quality Assurance Performance Improvement Committee monthly for additional recommendations as necessary. Compliance Date: 6/27/2015</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155198	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 05/28/2015
--	---	---	---

NAME OF PROVIDER OR SUPPLIER MARQUETTE	STREET ADDRESS, CITY, STATE, ZIP CODE 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
	<p>A review of the facility policy on 05-27-15 at 9:45 a.m., titled "Ordering, Changing and Discontinuing Orders," dated as revised 01-01-2013, indicated the following:</p> <p>"If Pharmacy receives a new order that changes the strength or dose of a medication previously ordered, and there is adequate supply on hand: If permitted by Applicable Law, Facility should notify Pharmacy not to send the medication by attaching a "Change in Directions" sticker to the existing quantity of medications until Pharmacy permanently affixes the new label to the medication package or container."</p> <p>A review of a subsequent policy on 05-27-15 at 9:45 a.m., titled "Storage and Expiration of Medications, Biologicals, Syringes and Needles," dated 01-01-2013, indicated the following:</p> <p>"Facility should store Schedule 2 controlled substances and other medications deemed by Facility to be at risk for abuse or diversion in a separate compartment within the locked medication carts and should have a different key or access device."</p> <p>3.1-25(k)(5)</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155198	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 05/28/2015
--	---	---	---

NAME OF PROVIDER OR SUPPLIER MARQUETTE	STREET ADDRESS, CITY, STATE, ZIP CODE 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 0465 SS=E Bldg. 00	<p>3.1-25(n)</p> <p>483.70(h) SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRON The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. Based observation and interview, the facility failed to ensure the resident furnishings were in good repair, in that the wooden tables and chairs in 2 of 3 resident dining areas were marred.</p> <p>Findings include:</p> <p>During an observation on 05-22-15 at 8:15 a.m. the following were observed:</p> <p>The Assist Resident Dining Room - 3 of 3 chairs with wooden legs and 8 of 8 table legs as well as paneling had scratches too numerous to count. The Independent Dining area had 7 of 7 chairs with scratches and 2 of 2 tables with scratches, which were too numerous too count.</p> <p>The marred areas were deeply scratched where the light colored wood could be observed.</p> <p>During an interview on 05-28-15 at 2:40 p.m., the Administrator indicated the</p>	F 0465	<p>F 465 483.70(h) Safe/Functional/Sanitary/Comfortable Environment 1. What corrective action will be accomplished for those resident found to have been affected by the deficient practice; No resident was identified as being negatively impacted by the marred areas on the furniture. No resident has voiced a concern regarding this, as evidenced by the resident council meeting minutes and grievance log. 2. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken; All residents who take their meals in the dining room have the potential to be affected by the marred furniture. 3. What measure will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur; Plant staff will arrange for the refinishing of the tables and chairs. This will be done</p>	06/27/2015

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155198	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 05/28/2015
--	---	---	---

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
R 0000 Bldg. 00	<p>facility was renovating and ordering new furniture for remodeling. In addition the facility had a person who came to the facility biannually to touch up the scuff marks on the tables and chairs.</p> <p>3.1-19(f)(5)</p>		<p>incrementally, so as not to disrupt the resident's ability to dine. Renovation is in the planning stages and replacement furniture not been determined at this time. Monthly rounding will be completed by plant supervisor to assess furniture for any refinishing needs. (Attachment HC-9) 4. How the corrective actions will be monitored to ensure the deficient practice will not recur, what quality assurance program will be put into place; Results of monthly rounding will be reviewed at monthly QAPI meeting. Recommendations will be given by the QAPI committee for further action. 5. Compliance date: June 27, 2015.</p>	
R 0273 Bldg. 00	<p>This visit was for a State Residential Licensure Survey.</p> <p>Residential Census: 57 Sample: 7</p> <p>The following residential findings were cited in accordance with 410 IAC 16.2-5.</p> <p>410 IAC 16.2-5-5.1(f) Food and Nutritional Services - Deficiency (f) All food preparation and serving areas (excluding areas in residents ' units) are</p>	R 0000		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155198	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 05/28/2015
--	---	---	---

NAME OF PROVIDER OR SUPPLIER MARQUETTE	STREET ADDRESS, CITY, STATE, ZIP CODE 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
	<p>maintained in accordance with state and local sanitation and safe food handling standards, including 410 IAC 7-24.</p> <p>Based on observation, interview and record review, the facility failed to ensure the kitchen stored and prepared food under sanitary conditions for 1 of 1 kitchens. This deficient practice had the potential to affect 64 of 64 residents residing in the facility.</p> <p>Findings include:</p> <p>During the initial tour of the facility kitchen on 05-18-15 at 10:15 a.m., with the Food Service Supervisor and the Executive Chef in attendance the following was observed:</p> <p>5 of 5 pans identified by the Executive Chef as large braising had a black heavy build up of a black substance.</p> <p>2 of 3 "large pots" had a dark brownish build up with a chauky color identified as "hard water deposits" by the Executive Chef.</p> <p>1 of 3 coffee thermos' had a brown build up from the upper edge of the opening of the thermos to the bottom surface.</p> <p>The ice cream freezer had green spillage across the bottom.</p>	R 0273	<p>R 273 410 IAC 16.2-5-5.1(f) R 273 Food Procure, Store/Prepare/Serve-Sanitary 1. What corrective actions will be accomplished for those residents found to have been affected by the deficient practice: No specific resident was found to be affected by this practice. 2. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken; All resident being served from the main kitchen have the potential to be affected by this practice. Basil, Spinach and onions were thrown away in front of surveyor, although invoices indicate that the Spinach was purchased two days previously and the green onions were purchased three days earlier. Roasting pans were disposed of and new ones ordered. Pots identified were disposed of and new ones ordered. Coffee thermoses were cleaned. Muffin pans were disposed of and new ones purchased. Plant replaced gripper strips in the walk in cooler. Lids on the spices were closed during kitchen tour. Ice cream cooler was cleaned. 3. What measures will be put into place or what systemic changes will be made to</p>	06/27/2015

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 05/28/2015
NAME OF PROVIDER OR SUPPLIER MARQUETTE			STREET ADDRESS, CITY, STATE, ZIP CODE 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	
	<p>1 of 3 muffin tins had a black build up of a burnt on substance.</p> <p>The threshold of the walk in cooler had pieces of gripper strips were frayed and worn. The Executive Chef indicated the gripper strips needed to be replaced.</p> <p>The "Old Bay Spice," although dated was open.</p> <p>The "Ground Ginger," although dated was open.</p> <p>Refrigerator #2 had two plastic bags of "Basil" were opened and undated. A bag of Spinach was opened and undated. The Green Onions were dated, but were not sealed.</p> <p>During this observation the Executive Chef indicated the items were to be dated and sealed when in the refrigerator.</p> <p>A review of the facility policy on 05-27-15 at 10:50 a.m., indicated the following:</p> <p>"Policy: It is the policy of the community to store foods under proper conditions of sanitation, temperature, light, moisture, ventilation and security."</p>		<p>ensure that the deficient practice does not recur; As indicated in the survey report, Marquette has a policy regarding food storage and kitchen sanitation. Chefs and Cooks have been re-educated on items identified during survey process. The Certified Dietary Manager will tour the kitchen with Chef and/ or Cooks, two times weekly for four weeks, then weekly thereafter, documenting findings. (Attachment HC-7) 4. How the corrective actions will be monitored to ensure the deficient practice will not recur, what quality assurance program will be put into place; The Certified Dietary Manager or designee is conducting quality improvement audits of the kitchen including weekly inspections. Results of the weekly inspections and all audits are being reported to the Quality Assurance Performance Improvement Committee quarterly for additional recommendations as necessary.</p> <p>5. Compliance Date: June 27, 2015</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155198	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 05/28/2015
--	---	---	---

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
R 0304 Bldg. 00	<p>"Procedure: 1. Food storage areas shall be clean at all times... 14. Leftover foods are labeled, dated, immediately placed under refrigeration and used within 72 hours or discarded... 16. All exposed foods should be stored tightly covered."</p> <p>410 IAC 16.2-5-6(e) Pharmaceutical Services - Deficiency (e) Medicine or treatment cabinets or rooms shall be appropriately locked at all times except when authorized personnel are present. All Schedule II drugs administered by the facility shall be kept in individual containers under double lock and stored in a substantially constructed box, cabinet, or mobile drug storage unit.</p> <p>Based on observation and interview, the facility failed to ensure the security of medications, in that during the medication administration, the nursing staff left medications and the medication cart unattended for 2 of 2 observations.</p> <p>Findings include:</p> <p>During the medication administration pass on 05-26-15 at 8:00 a.m., QMA (Qualified Medication Aide) #1 prepared medications for Resident #1. The medications included Aspirin (a pain medication) 81 mg, Calcium 600 with Vitamin D (supplement), Donepezil (a</p>	R 0304	<p>R 304 410 IAC 16.2-5-6(e)</p> <p>1. What corrective actions will be accomplished for those residents found to have been affected by the deficient practice; No resident was affected by this practice. When questioned, QMA explained that she thought the medications could be safely left in the presence of the surveyor because she was an RN. 2. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken; All residents being given medication have the potential to be affected by this practice. 3. What</p>	06/27/2015

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155198	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 05/28/2015
--	---	---	---

NAME OF PROVIDER OR SUPPLIER MARQUETTE	STREET ADDRESS, CITY, STATE, ZIP CODE 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
	<p>medication for Alzheimers disease), Requip (a medication for restless legs), Folic acid (a supplement), spectrovite (a supplement), vitamin E (a supplement), Macu Health (a supplement) and Lubricant eye drops.</p> <p>The QMA knocked on the door of the resident's room and requested to enter. The resident gave permission to enter. The QMA entered the resident's room and closed the door. The QMA placed the cup, which contained the medications on the resident's table and then stated she needed to exit the room in order to obtain gloves. The QMA exited the resident room leaving the medications unattended.</p> <p>During the medication administration pass on 05-26-15 at 8:50 a.m., QMA (Qualified Medication Aide) #2 prepared medications for Resident #5. The QMA prepared the medications into a plastic cup, and then stated she needed to leave for a "moment." As the QMA left the area, the medication VitaEyes was left on top of the medication cart unattended.</p> <p>During an interview on 05-28-15 at 10:30 a.m., the Director of Health Care indicated, "I've told them they should never leave medications or carts unattended."</p>		<p>measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur; Med pass staff will be in-serviced on not leaving medication un- attended, by themselves, at any time. These in-services will be held on June 16th and 18th. Director of Residential Services will monitor med pass 2 x weekly for two weeks, weekly for four weeks and then monthly thereafter to ensure medications are not left unattended. (Attachment R-2)</p> <p>4. How will the corrective action be monitored to ensure the deficient practice does not recur or what quality assurance program will be put into place; Results of the med pass audit will be presented at the quarterly QAPI meeting. QAPI committee will make appropriate recommendations, regarding additional audit need. 5.</p> <p>Compliance Date; June 27, 2015</p>	

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 12/07/2015

FORM APPROVED

OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155198	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____		X3) DATE SURVEY COMPLETED 05/28/2015
NAME OF PROVIDER OR SUPPLIER MARQUETTE			STREET ADDRESS, CITY, STATE, ZIP CODE 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	