STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155198	A. BUILDING 00 B. WING	06/10/2025

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

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F 0000 Bldg. 00	This visit was for the Investigation of Complaint IN00459646. Complaint IN00459646 - No deficiencies related to the allegation are cited. Unrelated deficiencies are cited. Survey date: June 10, 2025. Facility number: 000105 Provider number: 155198 Census Bed Type: SNF: 52 Total: 52 Census Payor Type: Medicare: 12 Other: 40 Total: 52 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review was completed on June 17, 2025.	F 0000	Preparation and execution of this plan of correction in no way constitutes an admission or agreement by Marquette of the truth of the facts alleged in this statement of deficiency and plan of correction. In fact, this plan of correction is submitted exclusively to comply with state and federal law. Marquette reserves the right to challenge legal proceedings, all deficiencies, statements, findings, facts and conclusions that form the basis of the stated deficiency. This plan of correction serves as the allegation of compliance.	
F 0689 SS=G Bldg. 00	483.25(d)(1)(2) Free of Accident Hazards/Supervision/Devices Based on observation, interview and record review, the facility failed to ensure hospital recommendations related to transfers were followed to ensure a resident was free of accidents for 1 of 2 residents reviewed for accidents. (Resident B) This deficient practice resulted in Resident B sustaining an acute distal	F 0689	I Resident B was affected and is resolving without complications. It is the practice of Marquette to ensure recommendations related to residents' transfers are followed to prevent accidents. Care plan and	06/30/2025

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Jeffrey Cox	Administrator/ED	06/30/2025

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

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	tibia fracture (a break in the lower end of the tibia, often near the ankle joint). Findings include: During an observation, on 6/10/25 at 10:43 a.m., Resident B was sitting in a wheelchair, her right lower extremity was noted to be in a cast, and she was wearing a brace around her mid-section. A facility reported incident (FRI) indicated, on 5/21/25, the CNA assisted Resident B with ambulating to the toilet. During ambulation, the resident fell toward her right side and her right ankle appeared to roll. Resident B voiced complaints of right ankle pain. The clinical record for Resident B was reviewed on 6/10/25 at 10:20 a.m. The diagnoses included, but were not limited to, wedge compression fracture of third lumbar vertebra, wedge compression fracture of second lumbar vertebra, and wedge compression fracture of T9-T10 vertebra. A preadmission hospital occupational therapist progress note, dated 5/16/25, indicated "...Restrictions/Precautions...2 staff assist for safety..." The equipment used during therapy was a gait belt and rolling walker. "...PLEASE NOTE: If this patient is discharged from acute care prior to the next treatment session, this note will serve as the discharge summary indicating the patient's current functional status...." A preadmission hospital physical therapist progress note, dated 5/16/25, indicated "...Restrictions/Precautions...2 staff assist for safety...Transfers...Stand Pivot...Moderate Assistance...Transfer Comment...With rolling		Kardex were reviewed and current to the resident's transfer status. II All newly admitted residents from the hospital and/or an outside community have the potential to be affected. An audit has been conducted of all newly admitted residents in the past 30 days for review of recommended transfer status. Transfer status has been reviewed and updated as applicable and therapy provided communication per evaluation. Resident Transfer status is confirmed to be in resident care plan and Kardex. III The Safe Lifting and Movement of Residents Policy and the Abuse Prevention Program Policy have been reviewed and found to meet clinical standards. Education provided to Health Center Nursing Staff on the Safe Lifting and Movement of Residents Policy and the Abuse Prevention Program Policy including proper transfer procedure and transfer competencies, including location of the residents transfer status and assistance needed. Additional systemic changes are being addressed through our quality assurance process described below. IV The Director of Nursing and/or designee will: Audit all newly admitted residents'	

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	walker from bed to chair...Gait...Distance 3 ft (feet)...PLEASE NOTE: If this patient is discharged from acute care prior to the next treatment session, this note will serve as the discharge summary indicating the patient's current functional status...." Resident B was admitted to the facility on 5/20/25. A facility document, titled "PRE-ADMISSION NEEDS ASSESSMENT," dated 5/20/25, indicated the resident was a fall risk and used a wheelchair, a walker, and was full weight bearing. A facility fall-risk assessment, dated 5/20/25, indicated the resident was chair bound. A Basic Interview for Mental Status (BIMS) assessment, dated 5/26/25, indicated Resident B had severe cognitive impairment. A nursing progress note, dated 5/21/25 at 4:59 p.m., indicated the nurse was called to the room and the resident was noted to be lying straight out on her back. The CNA reported Resident B stood with the walker, took a step, and began to fall toward the right. Resident B had her nonskid socks and her TLSO brace (a brace used to limit motion in the thoracic, lumbar, and sacral regions of the spine) on. There was no documentation in Resident B's clinical record to indicate more than one (1) staff member was present to assist Resident B. A typed statement from CNA 2, undated, indicated CNA 2 entered Resident B's room at approximately 2:20 p.m. The resident asked to use the restroom. A walker labeled "Therapy" was placed in front of Resident B. Resident B stood		transfer status to ensure the recommended transfer procedure is followed, five times weekly for 8 weeks, then weekly for 8 weeks, then monthly for total duration of 6 months. Additionally, transfer competencies will occur with three random health center nursing staff weekly for a total duration of 6 months. Results of all audits will be brought to QAPI for review and revision as needed. The audits will be reviewed by Quality Assurance Committee until such time consistent substantial compliance has been achieved as determined by the committee. The Administrator and Director of Nursing will be responsible for sustained compliance. This will be submitted to QAPI monthly for review. V. The facility will be in and remain in compliance by: June 30, 2025.	

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	up, walked to the bathroom, used the bathroom, and washed her hands. On the way back to her recliner, the resident's ankle "...folded towards her left ankle..." and the resident fell. The CNA called out for help. The nurse responded with another nurse and another CNA. The resident was assessed and the three staff members transferred the resident, using a gait belt, to the bed. An x-ray report of the right ankle, dated 5/21/25, indicated Resident B had sustained an acute distal tibia fracture. During an interview, on 6/10/25 at 11:48 a.m., LPN 2 indicated when she arrived at the room on the day of the incident, Resident B was lying on the floor between her bed and the bathroom. The resident was laying on her back and she was wearing her TLSO brace. Resident B was assisted off the floor by three staff using a gait belt. During an interview, on 6/10/25 at 1:46 p.m., the Therapy Manager indicated Resident B had been evaluated by therapy the same day as the fall. Resident B was a moderate to maximum transfer to the wheelchair due to the resident's cognition. Resident B's gait (manner of walking/moving) was zero feet, and her wheelchair mobility was 10 feet. She indicated prior to the fall Resident B should have been in a wheelchair. During a telephone interview, on 6/10/25 at 1:51 p.m., CNA 2 indicated she had walked into the resident's room about 2:30 p.m., a walker was located beside the bedside table and in reach of the resident. The resident requested to use the bathroom. The CNA indicated she was going to get assistance from another staff member, but Resident B had already stood up. CNA 2 indicated she could not leave the resident and did not want			

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	to be direct with the resident. She did not know the resident or how Resident B would react. She assisted the resident to the bathroom. Once Resident B was finished and a couple feet away from her recliner, the resident fell towards her right, onto her right hip. CNA 2 indicated Resident B was using the walker and the CNA did not have a gait belt at that time. There was a walker and a wheelchair in the room. This was her first time assisting Resident B. She indicated the facility did have sheets which told the CNA's how to transfer residents, but there was no documentation related to Resident B on the sheet. During an interview, on 6/10/25 at 2:13 p.m., the Director of Nursing (DON) indicated the facility did encourage the use of gait belts. Prior to Resident B's fall and per the hospital, the resident was a moderate to max assist (50-75 percent of the work was completed by the care provider or assistive device). The facility would have initially used the hospital transfer status, received from the hospital in report. CNAs were educated on transfers upon hire and there were gait belts in every resident room. A current facility policy, titled "Safe Lifting and Movement of Residents," dated as last revised July 2017 and received from the Director of Nursing on 6/10/25 at 3:19 p.m., indicated "...In order to protect the safety and well-being of staff and residents, and to promote quality of care, this facility uses appropriate techniques and devices to lift and move residents...Resident safety, dignity, comfort and medical conditions will be incorporated into goals and decisions regarding the safe lifting and moving of residents...." A current facility policy, titled "ABUSE PREVENTION PROGRAM," dated May 2023 and			

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	received from the Director of Nursing on 6/10/25 at 3:18 p.m., indicated "...Neglect is defined as failure of the facility, its employees or service providers, to provide goods and services necessary to avoid physical harm, pain, mental anguish or emotional distress...." 3.1-45(a)(2)			