PRINTED: 02/27/2025

	JMAN SERVICES CAID SERVICES					RM APPROVED B NO. 0938-039	
STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155198		A. BU	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING			(X3) DATE SURVEY COMPLETED 02/05/2025	
	ER.	STREET ADDRESS, CITY, STATE, ZIP COD 8140 TOWNSHIP LINE RD INDIANAPOLIS, IN 46260					
(EACH DEFICIE	NCY MUST BE PRECEDED BY FULL	1	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE	(X5) COMPLETION DATE	
Licensure Survey. Residential Licens Survey dates: Januard 5, 2025. Facility number: 0 Provider number: Census Bed Type: SNF: 52 Residential: 70 Total: 122 Census Payor Typ Medicare: 8 Other: 44 Total: 52 These deficiencies accordance with 4	This visit included a State ture Survey. Party 30, 31 and February 3, 4 00105 155198 e: Preflect State Findings cited in 10 IAC 16.2-3.1.	F 00	00	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 pof correction. In fact, this plan correction is submitted excluse to comply with state and fede law. Marquette reserves the to challenge in legal proceediall deficiencies, statements, findings, facts and conclusion that form the basis of the state deficiency. This plan of correserves as the allegation of compliance.	ne is lan n of sively ral right ngs, s ed ction		
Medicaid/Medica Based on interview failed to provide a Non-Coverage (No Skilled Nursing Fa Notice of Non-Coverage)	v and record review, the facility Notice of Medicare OMNOC) document and a acility Advance Beneficiary verage (SNF ABN) document	F 05	82	no negative consequences from the alleged deficient practice. the practice of Marquette to	om It is	03/07/2025	
	PROVIDER OR SUPPLIE SUMMARY (EACH DEFICIE REGULATORY C This visit was for a Licensure Survey. Residential Licens Survey dates: Januand 5, 2025. Facility number: 0 Provider number: Census Bed Type: SNF: 52 Residential: 70 Total: 122 Census Payor Typ Medicare: 8 Other: 44 Total: 52 These deficiencies accordance with 4 Quality review wa 2025. 483.10(g)(17)(18 Medicaid/Medicaid Based on interview failed to provide a Non-Coverage (No Skilled Nursing Fa Notice of Non-Co- prior to the end of	PROVIDER OR SUPPLIER ETTE SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION This visit was for a Recertification and State Licensure Survey. This visit included a State Residential Licensure Survey. Survey dates: January 30, 31 and February 3, 4 and 5, 2025. Facility number: 000105 Provider number: 155198 Census Bed Type: SNF: 52 Residential: 70 Total: 122 Census Payor Type: Medicare: 8 Other: 44 Total: 52 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review was completed on February 7, 2025. 483.10(g)(17)(18)(i)-(v) Medicaid/Medicare Coverage/Liability Notice Based on interview and record review, the facility failed to provide a Notice of Medicare Non-Coverage (NOMNOC) document and a Skilled Nursing Facility Advance Beneficiary Notice of Non-Coverage (SNF ABN) document prior to the end of service date for 1 of 3 residents	NT OF DEFICIENCIES OF CORRECTION IDENTIFICATION NUMBER 155198 PROVIDER OR SUPPLIER ETTE SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION This visit was for a Recertification and State Licensure Survey. This visit included a State Residential Licensure Survey. 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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

(X6) DATE

policy, procedure and to State and

TITLE

Jeffrey Cox Administrator 02/21/2025

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.

FORM CMS-2567(02-99) Previous Versions Obsolete Event ID: E0PK11 Facility ID: 000105 If continuation sheet Page 1 of 20

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	T OF HEALTH AND HUI R MEDICARE & MEDIC					B NO. 0938-039
STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155198		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 02/05/2025	
NAME OF	PROVIDER OR SUPPLIEF	1	8140 T	ADDRESS, CITY, STATE, ZIP COD OWNSHIP LINE RD IAPOLIS, IN 46260		
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OF	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY) Federal Guidelines and	ΓE	(X5) COMPLETION DATE
	a. The NOMNOC of 44's Medicare Part end on 8/22/24 and the current Medicar of 8/22/24. The doc had the right to requivelent on the day before the 6/22/24. Resident 44 was producted document on 9/9/24 service date. b. The SNF ABN did 44's Medicare Part would end on 8/21/ the services of Physical Part of the services of Physical Part of the North ABN did and on 8/21/ the services of Physical Part of the North ABN did and on 8/21/ the services of Physical Part of the North ABN did and on 8/21/ the services of Physical Part of the North ABN did and on 8/21/ the services of Physical Part of the North ABN did and on 8/21/ the services of Physical Part of the North ABN did and the Part of the	I SNF ABN documents for eviewed on 2/4/25 at 8:50 a.m. Idocument indicated Resident A coverage of services would Medicare would not pay for re skilled services after the date rument indicated Resident 44 mest an appeal. The appeal requested no later than noon of effective end of service date of a service with the NOMNOC At 13 days after the end of services 24 and beginning on 8/23/24, sical Therapy and apy would be out of pocket		Federal Guidelines and Regulations. II All residents who discharge that are receiving Medicare Coverage have the potential to be affected. Audits were conducted by Social Services and no other NOMNO for residents who were dischar from the community were issue late. III The Medicare Adva Beneficiary and Medicare Non-Coverage Notices Policy reviewed by the Administrator DON and found to meet clinical standards of care. The Director Nurses provided education to social Services Coordinator or timeframe for issuing NOMNC/ABN notices. IV The IDT team and/ordesignee will: Audit all NOMNC notice dates	cs rged ed nce was and al or of the n the	
	_	ovided with the SNF ABN 4, 15 days after the end of		issued for discharged resident weekly in Medicare meetings. NOMNCs issued will be review monthly during triple check		
	Social Service Dire were "out of town" beneficiary notices should have been p	w, on 2/3/25 at 9:09 a.m., the ctor indicated therapy staff when Resident 44's were due. The documents rovided to the resident 48 and of service date to give the beal the decision.		meeting. Audits will be comple weekly for a total duration of 1 months. Additional audits will be completed based upon the levicompliance. Results of all audits will be brought to QAPI for reviand revision as needed. The a will be reviewed by Quality	2 pe el of lits iew	

FORM CMS-2567(02-99) Previous Versions Obsolete

A current facility policy, titled "Medicare

Advance Beneficiary and Medicare

Event ID:

E0PK11

Facility ID: 000105

If continuation sheet

Assurance Committee until such

time consistent substantial

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PRINTED: 02/27/2025

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DEPARTMENT	CPARTMENT OF HEALTH AND HUMAN SERVICES					FOI	RM APPROVED	
CENTERS FOR MEDICARE & MEDICAID SERVICES						OM	B NO. 0938-039	
STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION			NSTRUCTION	(X3) DATE	SURVEY			
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	A. BUILDING 00		COMPL	ETED	
		155198	B. WING		02/05/	/2025		
NAME OF PROVIDER OR SUPPLIER MARQUETTE				8140 TO	ADDRESS, CITY, STATE, ZIP COD DWNSHIP LINE RD APOLIS, IN 46260			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT	TE	COMPLETION	
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE	
	Non-Coverage Noti	ces," dated as last revised		·	compliance has been achieved	d as		

MARQUI	LIIL	INDIAN		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 0583	Non-Coverage Notices," dated as last revised September 2022 and received from the Director of Nursing on 2/4/25 at 11:00 a.m., indicated "Residents are informed in advance when changes will occur to their billThe facility issues the Skilled Nursing Facility Advance Beneficiary Notice (CMS form 10055) for the following triggering eventsTermination-In the situation in which the facility proposes to stop furnishing all extended care items or services to a beneficiary because it expects that Medicare will not continue to pay for the items or services that a physician has ordered and the beneficiary would like to continue receiving the care, the SNF ABN is issued to the beneficiary before such extended care items or services are terminatedIf the resident's Medicare covered Part A stay or when all of the Part B therapies are ending, a Notice of Medicare Non-Coverage (CMS form 10123) is issued to the resident at least two calendar days before benefits end" 3.1-4(f)(1)(A) 3.1-4(f)(1)(B) 3.1-4(f)(2)		compliance has been achieved as determined by the committee. V The Administrator and Social Service Coordinator will be responsible for sustained compliance. The facility will be in and remain in substantial compliance by: March 7, 2025.	
SS=D Bldg. 00	Personal Privacy/Confidentiality of Records Based on observation, interview and record review, the facility failed to ensure privacy was provided during a medication administration for 1 of 1 resident reviewed for privacy. (Resident 19) Findings include: During an observation, on 1/30/25 at 10:41 a.m., Resident 19 was sitting in a wheelchair on her side of a shared room. QMA 5 was observed to administer eye drops to Resident 19. The privacy	F 0583	I Resident #19 continues to reside in the community. The QMA was educated by the Director of Nursing on the Resident Rights Policy (which included the right to privacy) immediately after not providing privacy during eye drop administration. It is the practice of Marquette to provide residents with personal privacy.	03/07/2025

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

E0PK11

Facility ID: 000105

If continuation sheet

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155198		(X2) MULTIPLE CONSTRUCTION (X3) DATE A. BUILDING 00 COMPL B. WING 02/05,		ETED			
NAME OF P	ROVIDER OR SUPPLIER			8140 T	ADDRESS, CITY, STATE, ZIP COD DWNSHIP LINE RD APOLIS, IN 46260		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL	Pl	REFIX	(EACH CORRECTIVE ACTION SHOULD BE	TC	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	IE	DATE
	curtain had not been	n pulled to obscure the view of					
	a visitor on the other	er side of the shared room. The			II All residents have	the	
	visitor had an unobstructed view of the care being provided to Resident 19.				potential to be affected. All		
					licensed nursing staff and QM.	As	
					were educated on the Resider		
	At that time, QMA	5 indicated the privacy curtain			Rights Policy and the right to		
		losed when providing all care.			privacy while administering		
		1 5			medications.		
	During an interview	y, on 2/4/25 at 3:19 p.m., the					
	_	indicated the facility followed			III The facility's policy	on	
	the state and federa	•			Resident Rights was reviewed		
					found to meet the clinical		
	A current facility po	olicy, titled "Resident Rights,"			standards of practice. The		
		February 2021 and received			Director of Nursing provided		
		f Nursing on 1/31/25 at 8:55			education to Health Center		
		ederal and state laws guarantee			Licensed Nursing and QMA st	aff	
		to all residents of this facility.			on Residents Rights and the ri		
		e the residents' right			to privacy while providing care	-	
	toprivacy and con	_					
	1 3	,			IV The Director of Nur	sina	
	3.1-3(p)(2)				and/or designee will:	9	
	3.1-3(p)(4)				Conduct medication administra	ation	
	****				observations for privacy week	lv x	
					12 weeks, then monthly for a t	-	
					duration of 12 months. Result		
					the audits will be reported to the	ne	
					QAPI committee monthly.		
					Additional audits will be compl	eted	
					based upon the level of		
					compliance. The audits will be	Э	
					reviewed by Quality Assurance		
					Committee until such time that		
					consistent substantial complia		
					has been achieved as determi		
					by the committee.		
					V The Administrator	and	
					Director of Nursing will be		
					responsible for sustained		
					compliance. The facility will be	e in	

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER		I	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER 155198	A. BU B. W.		00	COMPLETED 02/05/2025	
		155196	B. W.	ING	_	02/05/	2025
NAME OF F	PROVIDER OR SUPPLIER	S.		8140 T	ADDRESS, CITY, STATE, ZIP COD OWNSHIP LINE RD JAPOLIS, IN 46260		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	CROSS-REFERENCED TO THE APPROPRIATE		COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY		DATE
					and remain in compliance by March 7, 2025.		
F 0657	483.21(b)(2)(i)-(iii)	1	İ				
SS=D Bldg. 00	Care Plan Timing	and Revision					
		and record review, the facility	F 0	657	I Residents #36 and	d	03/07/2025
		e plan meetings were			#37 had no negative		
		resident and/or resident's			consequences from the allege		
	•	of 8 residents reviewed for			deficient practice. Resident #3	36	
	care plan meetings.	(Resident 36 and 37)			and daughter attended care		
	TO 11 1 1 1				conference on February 7, 20		
	Findings include:				Resident #37 and daughter in	vited	
	1 Dyning on intervi	ov. on 1/20/25 at 10:22 a m			to attend care conference on		
	_	ew, on 1/30/25 at 10:33 a.m., a Resident 36 indicated they had			February 3, 2025, invitation	14:-	
	-	plan meeting for a year.			declined, and record updated.	IT IS	
	not attended a care	plan meeting for a year.			the practice of Marquette to	o oro	
	The clinical record:	for Resident 36 was reviewed			ensure care planning meeting scheduled with the resident ar		
		m. The diagnoses included, but			resident representative.	IU/OI	
		severe dementia with mood			resident representative.		
	· ·	depressive disorder, and mood			II All residents have	the	
	disorder.	depressive disorder, and mood			potential to be affected. An au		
	uiseruur.				has been conducted for all	uit	
	The last documente	d care plan meetings were held			residents' medical records for	the	
	on 3/14/24 and 6/28	-			past 3 months to ensure resid		
					and residents' representatives		
	2. During an intervi	ew, on 1/30/25 at 10:29 a.m., a			have been provided with the		
	family member for	Resident 37 indicated they had			opportunity to participate in th	е	
	not had a care plan	meeting in a year.			residents' care planning. Any		
					discrepancies have been corre	ected	
	The clinical record	for Resident 37 was reviewed			with the offer of a care plan		
		m. The diagnoses included, but			meeting.		
		age-related physical debility,					
	constipation, and pa	in.			III The Care Planning		
					Policy was reviewed by the		
		d care plan meeting was held			Administrator and Director of		
	on 5/6/24.				Nursing and found to meet cli	nical	
					standards.		
	During an interview	y, on 2/3/25 at 9:12 a.m., the			Education provided to Social		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155198 STREET ADDRESS, CITY, STATE, ZIP COD 8140 TOWNSHIP LINE RD INDIANAPOLIS, IN 46260 (X4) ID PREFIX TAG SOcial Services Worker indicated care plan conferences were to be completed quarterly and a note was to be put into the medical record. Social Services Worker indicated she did not have any care plan notes for the missed care plan meetings. She did talk with the families and if they told her everything was "o.k." or if they did not X2) MULTIPLE CONSTRUCTION A. BUILDING D. X3) DATE SURVEY COMPLETED OQ/05/2025 STREET ADDRESS, CITY, STATE, ZIP COD 8140 TOWNSHIP LINE RD INDIANAPOLIS, IN 46260 (X5) PREFIX TAG PROVIDER'S PLAN OF CORRECTION GEACH CORRECTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY. DEFICIENCY DEFICIENCY DEFICIENCY TAG Services Coordinator on Care Planning Policy, including education on updating medical records with explanation for declined meeting. IV The Social Service Coordinator and/or designee will: Conduct care plan meeting audit		
NAME OF PROVIDER OR SUPPLIER MARQUETTE STREET ADDRESS, CITY, STATE, ZIP COD 8140 TOWNSHIP LINE RD INDIANAPOLIS, IN 46260 (X4) ID PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION Social Services Worker indicated care plan conferences were to be completed quarterly and a note was to be put into the medical record. Social Services Worker indicated she did not have any care plan notes for the missed care plan meetings. She did talk with the families and if they STREET ADDRESS, CITY, STATE, ZIP COD 8140 TOWNSHIP LINE RD INDIANAPOLIS, IN 46260 (X5) PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCEDED 10 THE APPROPRIATE DEFICIENCY) DATE Services Coordinator on Care Planning Policy, including education on updating medical records with explanation for declined meeting. IV The Social Service Coordinator and/or designee will:	(X3) DATE SURVEY	
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MARQUETTE Summary statement of deficiencie ID PROVIDERS PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOLLD BE COMPLETION) COMPLETION (EACH CORRECTIVE ACTION SHOLLD BE COMPLETION) COMPLETION (EACH CORRECTIVE ACTION SHOLLD BE COMPLETION) COMPLETION DATE		
(X4) ID PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION Social Services Worker indicated care plan conferences were to be completed quarterly and a note was to be put into the medical record. During an interview, on 2/3/25 at 12:02 p.m., the Social Services Worker indicated she did not have any care plan notes for the missed care plan meetings. She did talk with the families and if they ID PROVIDER'S PLAN OF CORRECTION (CACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) DATE Services Coordinator on Care Planning Policy, including education on updating medical records with explanation for declined meeting. IV The Social Service Coordinator and/or designee will:		
PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION Social Services Worker indicated care plan conferences were to be completed quarterly and a note was to be put into the medical record. During an interview, on 2/3/25 at 12:02 p.m., the Social Services Worker indicated she did not have any care plan notes for the missed care plan meetings. She did talk with the families and if they PREFIX TAG PREFIX TAG PREFIX TAG Services Coordinator on Care Planning Policy, including education on updating medical records with explanation for declined meeting. IV The Social Service Coordinator and/or designee will:		
PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION Social Services Worker indicated care plan conferences were to be completed quarterly and a note was to be put into the medical record. During an interview, on 2/3/25 at 12:02 p.m., the Social Services Worker indicated she did not have any care plan notes for the missed care plan meetings. She did talk with the families and if they PREFIX TAG PREFIX TAG PREFIX TAG Services Coordinator on Care Planning Policy, including education on updating medical records with explanation for declined meeting. IV The Social Service Coordinator and/or designee will:		
Social Services Worker indicated care plan conferences were to be completed quarterly and a note was to be put into the medical record. During an interview, on 2/3/25 at 12:02 p.m., the Social Services Worker indicated she did not have any care plan notes for the missed care plan meetings. She did talk with the families and if they Services Coordinator on Care Planning Policy, including education on updating medical records with explanation for declined meeting. IV The Social Service Coordinator and/or designee will:		
Social Services Worker indicated care plan conferences were to be completed quarterly and a note was to be put into the medical record. During an interview, on 2/3/25 at 12:02 p.m., the Social Services Worker indicated she did not have any care plan notes for the missed care plan meetings. She did talk with the families and if they Services Coordinator on Care Planning Policy, including education on updating medical records with explanation for declined meeting. IV The Social Service Coordinator and/or designee will:	I	
conferences were to be completed quarterly and a note was to be put into the medical record. During an interview, on 2/3/25 at 12:02 p.m., the Social Services Worker indicated she did not have any care plan notes for the missed care plan meetings. She did talk with the families and if they Planning Policy, including education on updating medical records with explanation for declined meeting. IV The Social Service Coordinator and/or designee will:		
note was to be put into the medical record. During an interview, on 2/3/25 at 12:02 p.m., the Social Services Worker indicated she did not have any care plan notes for the missed care plan meetings. She did talk with the families and if they education on updating medical records with explanation for declined meeting. IV The Social Service Coordinator and/or designee will:		
note was to be put into the medical record. Buring an interview, on 2/3/25 at 12:02 p.m., the Social Services Worker indicated she did not have any care plan notes for the missed care plan meetings. She did talk with the families and if they education on updating medical records with explanation for declined meeting. IV The Social Service Coordinator and/or designee will:		
During an interview, on 2/3/25 at 12:02 p.m., the Social Services Worker indicated she did not have any care plan notes for the missed care plan meetings. She did talk with the families and if they records with explanation for declined meeting. IV The Social Service Coordinator and/or designee will:		
During an interview, on 2/3/25 at 12:02 p.m., the Social Services Worker indicated she did not have any care plan notes for the missed care plan meetings. She did talk with the families and if they declined meeting. IV The Social Service Coordinator and/or designee will:		
Social Services Worker indicated she did not have any care plan notes for the missed care plan IV The Social Service meetings. She did talk with the families and if they Coordinator and/or designee will:		
any care plan notes for the missed care plan meetings. She did talk with the families and if they IV The Social Service Coordinator and/or designee will:		
meetings. She did talk with the families and if they Coordinator and/or designee will:		
want a care plan meeting then she did not of current residents weekly for 8		
schedule a meeting. She was aware that a care weeks, then every other week for 8		
plan meeting needed to be done, and the invite to weeks, then monthly for a total		
the meeting needed to be sent to the responsible duration of 12 months. Results of		
party/Power of Attorney and the resident. If they the audits will be reported to the		
did not want to attend, she was to document the QAPI committee monthly.		
information. Additional audits will be completed		
based upon the level of		
During an interview, on 2/4/25 at 3:19 p.m., the compliance. The audits will be		
Director of Nursing indicated the facility followed reviewed by Quality Assurance		
the state and federal regulations. Committee until such time that		
consistent substantial compliance		
A current facility policy, titled "Care Planning," has been achieved as determined		
dated as revised in March 2022 and received from by the committee.		
the Executive Director on 2/3/25 at 1:34 p.m., V. The Administrator and		
indicated "The interdisciplinary team is Social Service Coordinator will be		
care plans" compliance. The facility will be in		
and remain in compliance by		
3.1-35(a) March 7, 2025.		
3.1-35(d)(2)(B)		
F 0004		
F 0684 483.25		
SS=D Quality of Care		
Bldg. 00		
Based on interview and record review, the facility $F 0684$ I Resident #34 had $03/07/2025$	5	
failed to ensure the physician was notified when no negative consequences from		
blood sugars were out of the physician ordered the alleged deficient practice. It is		
parameters for 1 of 1 resident reviewed for quality the practice of Marquette to notify		
of care. (Resident 34) the physician of blood sugars		

outside of parameter range per the

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CENTERS FOR MEDICARE & MEDICAID SERVICES				OMB NO. 0938-039		
STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE C	CONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING	00	COMPLETED	
		155198	B. WING		02/05/2025	
NAME OF 1	PROVIDER OR SUPPLIER	<u> </u>		ADDRESS, CITY, STATE, ZIP COD		
				TOWNSHIP LINE RD		
MARQUI	ETTE		INDIA	NAPOLIS, IN 46260		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID		(X5)	
PREFIX		ICY MUST BE PRECEDED BY FULL	PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	COMPLETION	
TAG		R LSC IDENTIFYING INFORMATION	TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	DATE	
1110	Findings include:		1110	physician's orders.	5.112	
	i mamgs metade.			II All residents with a	an	
	The clinical record	for Resident 34 was reviewed		order for blood sugar checks h		
		m. The diagnoses included, but		the potential to be affected.	lave	
	_	type 2 diabetes, edema, and		An audit has been conducted	of all	
	chronic kidney dise			residents with blood check ord		
	cironic kidney dise	asc.			1612	
	A physician's arden	, dated 7/8/24, indicated to		for blood sugars outside of	in	
		s (blood sugar checks) 4 times		physician ordered parameters		
		e physician when the blood		the past 30 days for physician		
	-	an 70 or greater than 400.		notification and documentation	1.	
	sugars were less tha	in 70 or greater than 400.		Any discrepancies have been		
	A CD: 1-	2 41- 1-1		corrected.		
		nt 34's blood sugars indicated		III The Charting and		
	the following result			Documentation Policy reviewe	ed	
		sident's blood sugar was 69.		and found to meet clinical		
		sident's blood sugar was 65.		standards.		
		sident's blood sugar was 425.		Education provided to Health		
	On $1/5/25$, the resid	lent's blood sugar was 51.		Center Licensed Nursing staff	on	
				Charting and Documentation		
		nentation the physician was		Policy including following		
		d sugars which were out of the		physician's order for blood sug	- I	
		parameters found in the		parameters, physician notifica	l l	
	resident's record.			and documentation. Additiona	I	
	l			systemic changes are being		
	_	v, on 2/4/25 at 3:18 p.m., the		addressed through our quality		
	~	g (DON) indicated she could		assurance process described		
		ation for the blood sugars and		below.		
	the nurse should ha	ve notified the physician.		IV The Director of Nur	rsing	
	During an interview	y, on 2/5/25 at 11:09 a.m., the		or designee will:		
	DON indicated she			Audit all resident blood sugars	s for	
		blood sugars in the record.		results out of physician		
				parameters and notification of		
	A current facility po	olicy, titled "Charting and		provider, three times weekly for		
		ated as revised in 2017 and		weeks, then weekly for 8 weel	l l	
		OON on 2/4/25 at 3:17 p.m.,		then monthly for a total duration		
		nentation of procedures and		12 months. Results of all audit		
		ude care-specific details,		will be brought to QAPI for rev		
		tion of family, physician or		and revision as needed. The a		
1	,	acar or imiliary partitional Or	1	T and revision as necessar. The a	audito	

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other staff, if indicated...."

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will be reviewed by Quality

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155198		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY A. BUILDING 00 COMPLETED B. WING 02/05/2025			
NAME OF F	PROVIDER OR SUPPLIER	1	8140 T	ADDRESS, CITY, STATE, ZIP COD OWNSHIP LINE RD NAPOLIS, IN 46260	
(X4) ID	<u> </u>	STATEMENT OF DEFICIENCIE	ID	<u> </u>	(X5)
PREFIX TAG	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION	PREFIX TAG	PROVIDERS PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	COMPLETION DATE
	3.1-37(a)			Assurance Committee until su time consistent substantial compliance has been achieve determined by the committee. This will be submitted to QAPI monthly for review. V The Administrator Director of Nursing will be responsible for sustained compliance. The fa will be in and remain in compliance by March 7, 2025.	d as I and cility
F 0692 SS=D Bldg. 00	Based on interview failed to ensure staf weekly to monitor f physician's order an weights in the medi reviewed for nutritive. The clinical record 2/4/25 at 1:29 p.m. were not limited to, anorexia, and nutrity A nutritional note, or Registered Dietitian weekly weights for A progress note, dar	for Resident 8 was reviewed on The diagnoses included, but Barrette's esophagus,	F 0692	I Resident #8 had negative consequences from a alleged deficient practice. It is practice of Marquette to obtain weekly weights and correctly document according to physician's order. II All residents with a order for weekly weights have potential to be affected. An audit has been conducted residents with an order for weights for accurate documentation. Any discrepantave been corrected. III The Nutrition Risk a Weight Loss Management and Charting and Documentation Policy has been reviewed and found to meet clinical standard Education provided to Health	the the the an the of all ekly ancies and d
		indicated Resident 8 was to		Center Nursing staff on Nutriti	on

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OMB NO. 0938-039 STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING 00 COMPLETED B. WING 02/05/2025 155198 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 8140 TOWNSHIP LINE RD **MARQUETTE** INDIANAPOLIS, IN 46260 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE Monday, for weight loss starting 9/16/24. Management and Charting and Documentation Policy including A nutritional note, dated 11/7/24, indicated the RD documentation of weight in would continue weekly weights for closer medical record. Additional monitoring and would follow up with Resident 8's systemic changes are being intakes, weekly weights, and labs as available. addressed through our quality assurance process described The resident's medical record was missing below. documentation for the weekly weights in the months of September, November, January, and The Director of Nursing February. or designee will: Audit of all weekly weights for A review of a weight summary indicated that the documentation in medical record facility did not obtain weekly weights in the weekly x 12 weeks, then monthly months of September, November, December, for a total duration of 12 months. January, and February. Results of all audits will be brought to QAPI for review and During an interview, on 2/4/25 at 2:21 p.m., revision as needed. The audits will Licensed Practical Nurse 4 indicated when a be reviewed by Quality Assurance resident had an order for weekly weights, the Committee until such time weights were documented on a form kept at the consistent substantial compliance nurse's station and given to the unit manager has been achieved as determined when completed. by the committee. This will be submitted to QAPI monthly for During an interview, on 2/4/25 at 2:24 p.m., the review. Assistant Director of Nursing (ADON) indicated the weekly weight order should have been The Administrator and discontinued because Resident 8 was no longer Director of Nursing will be followed by the RD. responsible for sustained compliance. The facility During an interview, on 2/4/25 at 3:18 p.m., the will be in and remain in Director of Nursing (DON) indicated the resident compliance by March 7, 2025. was no longer being followed by the RD and the weekly weights should have been discontinued in October. She indicated the RD reviewed the note from 11/7/24 and acknowledged she documented to continue the weekly weights but given the stable weights the RD should have discontinued

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the order for the weekly weights. The order remained active, and the weights should have

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STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155198		(X2) MULTIPLE CO A. BUILDING B. WING	onstruction 00	(X3) DATE SURVEY COMPLETED 02/05/2025
NAME OF F	PROVIDER OR SUPPLIER	STREET A 8140 TO INDIAN		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION continued to be obtained according to the order.	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
	During an interview, on 2/4/25 at 3:39 p.m., the RD indicated the order for weekly weights should have been discontinued. The RD did not remove orders from the clinical record and noticed the order was still active when she visited Resident 8 in November. The RD documented to continue the weekly weights because the order was still active, and she thought the facility was still monitoring Resident 8's weights. A current facility policy, titled "Nutrition Risk and Weight Loss Management," dated as last reviewed/revised February 2024 and received from the DON on 2/5/25 at 8:20 a.m., indicated "Nursing assistant or designated personnel will weigh residents per policyResidents are weighed at least monthly unless there is a physician's order otherwise. The IDT or RD can request weights be completed weekly for monitoring as a nursing measure" A current facility policy, titled "Charting and Documentation," dated as revised 2017 and received from the DON on 2/4/25 at 3:17 p.m., indicated "Documentation in the medical record will be objectivecomplete, and accurate"			
F 0695 SS=D Bldg. 00	483.25(i) Respiratory/Tracheostomy Care and Suctioning Based on observation, interview and record review, the facility failed to ensure a physician's order was clear and accurate related to the correct oxygen liter flow rate for 1 of 2 residents reviewed for respiratory care. (Resident 10)	F 0695	I Resident #10 no longer resides in the communi and according to the O2 sats recorded Resident #10 was no affected by this alleged deficie practice. Resident physician o	ot nt

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY			
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	A. BUILDING <u>00</u>		COMPL	COMPLETED	
		155198	B. W	NG	_	02/05/	02/05/2025	
				_				
NAME OF I	PROVIDER OR SUPPLIE	R			ADDRESS, CITY, STATE, ZIP COD			
					OWNSHIP LINE RD			
MARQUI	ETTE			INDIAN	IAPOLIS, IN 46260			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX	(EACH DEFICIEN	NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE	тс	COMPLETION	
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	.16	DATE	
	Findings include:				was reviewed and updated. The	he		
					DON and Charge Nurse			
	During an observation, on 1/31/25 at 9:58 a.m.,				responsible for the residents'	care		
	Resident 10's oxygen flow rate was on 2-liters.				observed and verified that the			
	resident 100 oxygen new rate was on 2 mero.				flow was set per MD order. It i			
	The clinical record	for Resident 10 was reviewed			the practice of Marquette to			
	on 2/3/25 at 1:30 p.	.m. The diagnoses included, but			ensure physician's oxygen ord	ders		
	_	, chronic obstructed pulmonary			have a clear and accurate oxy			
		nronic respiratory failure, and			liter flow rate.	5		
	essential hypertens				II All residents who			
					utilize oxygen could be affecte	ed by		
	A physician's order, dated 1/8/25, indicated the				this alleged deficient practice.	-		
	oxygen flow rate was to be at 4 liters per minute				Physician order review and			
	via nasal cannula. The order summary indicated				observation of liter flow was			
	the oxygen flow rate was to be at 2 liters per				completed on all residents who	o		
	minute via nasal ca				utilize oxygen, and all were for			
					in compliance.			
	The order had 2 dif	ferent oxygen liter flow rates.			·			
					III The Oxygen			
	During an interview	v, on 2/3/25 at 1:48 p.m.,			Administration Policy was			
	Licensed Practical	Nurse (LPN) 3 indicated the			reviewed and found to meet			
	oxygen order was r	not a titration order. She			clinical standards. Education			
	thought the residen	t was to be on 4 liters but did			provided to Health Center			
	not see the 2 liters l	listed in the order summary.			Licensed Nursing Staff on the			
	She would have to	clarify the order because she			Oxygen Administration Policy			
	was not sure.				including verification of the oxy	ygen		
					physician order against liter flo	DW.		
	During an interview	v, on 2/3/25 at 1:55 p.m., the			Additional systemic changes a			
	Director of Nursing	g (DON) indicated she was not			being addressed through our			
	sure what the oxyg	en flow rate was supposed to			quality assurance process			
	be, and she would l	have to check.			described below.			
	During an interview	v, on 2/3/25 at 2:11 p.m., the			IV The Director of Nur	rsing		
	DON indicated Res	sident 10 was supposed to be			or designee will:			
	on 4 liters of oxyge	en.			Audit of compliance of oxygen	ı		
					orders and liter flow rates up to	o 5		
	A facility policy, ti	tled "Oxygen Administration,"			residents utilizing oxygen thre	е		
	dated as revised in	October 2010 and received			times weekly for 8 weeks, thei	n		
	from the DON on 2	2/4/25 at 3:20 p.m., indicated			weekly for 8 weeks, then mon	thly		
	"Turn on the oxy	gen. Unless otherwise ordered,			for a total duration of 12 montl	-		

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SU		SURVEY			
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING <u>00</u> COMPLETED			ETED	
		155198	B. WIN	NG		02/05/2025	
			<u> </u>	STREET A	ADDRESS, CITY, STATE, ZIP COD	<u> </u>	
NAME OF P	ROVIDER OR SUPPLIER				OWNSHIP LINE RD		
MARQUE	TTF				APOLIS, IN 46260		
1017 (1 (QOL	-116			11401/114/	711 OLIO, 114 40200		
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL	I	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE		COMPLETION
TAG		LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
		gen at the rate per physician			Results of all audits will be		
	order"				brought to QAPI for review and		
					revision as needed. The audits		
	3.1-47(a)(6)				be reviewed by Quality Assura	ance	
					Committee until such time		
					consistent substantial complia		
					has been achieved as determi	ned	
					by the committee. This will be		
					submitted to QAPI monthly for		
					review.		
					<u>.</u>		
					V The Administrator	and	
				Director of Nursing will be			
					responsible for		
					sustained compliance. The fa	CIIITY	
					will be in and remain in		
					compliance by March 7, 2025.		
F 0810	483.60(g)						
SS=D	Assistive Devices	- Fating					
Bldg. 00	Equipment/Utensil	•					
	• •	on, interview and record	F 08	F 0810 I Resident			03/07/2025
		failed to ensure a two (2)	1 00	10	longer resides in the community	tv	03/07/2023
		ilable for a resident's coffee for			and was not negatively affecte	-	
	-	ewed for adaptive equipment.			this alleged deficient practice.	-	
	(Resident 1)				handled insulated cups were		
	,				ordered and delivered to the		
	Findings include:				facility. It is the practice of		
					Marquette to ensure two hand	led	
	During an observati	on of the morning meal, on			cups are available.		
	2/3/25 at 8:35 a.m.,	Resident 1 was observed in the			II All residents requi	ring	
	dining room. She ha	nd two handle cups for her			a two handled cups have the		
	milk, juice and water	er with lids, but an insulated			potential to be affected by the		
	cup with only one h	andle for coffee.			alleged deficient practice. Care	е	
					plans and Kardex for all reside	ents	
	During an interview	y, on 2/3/25 at 8:25 a.m., the			who require assistance with		
	Dietary Manager (D	OM) indicated she was aware			consuming fluids in a two hand	dled	
	the resident needed	two (2) handle cups for her			cups were reviewed and upda	ted	
	drinks, but she did r	not think about the coffee and			as applicable.		
	the facility did not h	nave a two-handle insulated					

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Therapy Manager indicated the resident was

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STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155198			(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY A. BUILDING 00 COMPLETED B. WING 02/05/2025					
NAME OF P	PROVIDER OR SUPPLIER		8140 T	STREET ADDRESS, CITY, STATE, ZIP COD 8140 TOWNSHIP LINE RD INDIANAPOLIS, IN 46260				
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	(X5) COMPLETION DATE			
F 0842 SS=D Bldg. 00	with activities of da performed daily succurrently using two when she was disched A current facility policy and the performed daily succurrently using two when she was disched A current facility policy and the performance of the performance	policy, titled "Activities of Daily porting," dated as revised in reived from the Director of t 3:19 p.m., indicated provided with care, treatment are that their activities of daily of diminish" 70(i)(1)-(5) - Identifiable Information and record review, the facility tumentation was complete and the care provided for 2 of 2 for accurate documentation.	F 0842	I Resident #1 no longer resides in the communi Resident #46 and Resident #1 no negative consequences fro the alleged deficient practice. The practice of Marquette to ensure documentation is completed and accurate to reficare provided. II All residents have potential to be affected. No residents experienced any negative consequences from the alleged deficient practice. III The Charting and Documentation Policy was reviewed and found to meet clinical standards. Education provided to Health Center Licensed Nursing Staff on Charand Documentation Policy	had m It is lect the			

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

E0PK11

Facility ID: 000105

If continuation sheet

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STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER		a. building <u>00</u>		COMPLETED	
		155198	B. WI	B. WING		02/05/2025	
N	NOTABLE OF STATE		' 1	STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF PROVIDER OR SUPPLIER			l		OWNSHIP LINE RD		
MARQUE	TTE			INDIAN	IAPOLIS, IN 46260		
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL	1	PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		LISC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
		ent's vital signs twice a day.			including importance of timely		
		he treatment was not charted			documentation Additional		
		and Treatment record for			systemic changes are being		
	1/31/25 for the seco	ond snift.			addressed through our quality	'	
	2 The olimical recor	rd for Resident 1 was reviewed			assurance process described		
		m. The diagnoses included, but			below.		
		weakness, heart failure, and a			IV The Director of Nui	reina	
	need for assistance				or designee will:	Sirig	
	nood for assistance	personal care.			Audit 20% of residents for		
	A physician's order.	, initiated on 11/29/24,			completed Medication and		
		r for signs and symptoms of			Treatment Administration Rec	ord	
		ychoactive drugs every shift			documentation, three times	o. u	
	-	ysician if side effects were			weekly for 8 weeks, then week	klv	
		no documentation for the			for 8 weeks, then monthly for	-	
	-	the MAR/TAR for 12/5/24,			total duration of 12 months.		
	-	4 for the evening shift.			Results of all audits will be		
					brought to QAPI for review an	d	
	A physician's order,	, initiated on 11/29/24,			revision as needed. The audit		
	indicated to monito	r for signs and symptoms of			be reviewed by Quality Assura	ance	
	anti-coagulant medi	cations (used to thin the			Committee until such time		
	blood) every shift.	There was no documentation			consistent substantial complia	nce	
	for the monitoring f	found in the MAR/TAR for			has been achieved as determ	ined	
	12/5/24, 12/11/24 o	r 12/18/24 for the evening shift.			by the committee. This will be		
					submitted to QAPI monthly for	-	
		, initiated on 11/29/24,			review.		
		he resident for pain every					
		documentation for the			V The Administrator	and	
		the MAR/TAR for 12/5/24,			Director of Nursing will be		
	12/11/24 or 12/18/2	4 for the evening shift.			responsible for sustained		
					compliance. The facility will b	e in	
		indicated the resident was to			and remain in compliance by		
	be weight bearing (standing/walking) as tolerated on her bilateral lower extremities every shift. There				March 7, 2025.		
		ion for the monitoring found in					
		12/5/24, 12/11/24 or 12/18/24 for					
	the evening shift.						
	During an interview	on 2/5/25 at 0:10 a m the					
	During an interview, on 2/5/25 at 9:19 a.m., the Assistant Director of Nursing indicated the						

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		IDENTIFICATION NUMBER 155198	A. BUILDING 00 B. WING		COMPLETED 02/05/2025		
NAME OF PROVIDER OR SUPPLIER MARQUETTE			STREET ADDRESS, CITY, STATE, ZIP COD 8140 TOWNSHIP LINE RD INDIANAPOLIS, IN 46260				
(X4) ID PREFIX TAG	(EACH DEFICIENC	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	P.	ID REFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	Ē	(X5) COMPLETION DATE
R 0000 Bldg. 00	facility determined at the documentation in Treatment records of A current facility por Documentation," da 2017 and received fit 2/4/25 at 3:17 p.m., information is to be medical recordMe administeredTreat preformed" 3.1-50(a)(1) 3.1-50(a)(2) This visit was for a survey. This visit in State Licensure Survey dates: Januar and 5, 2025. Facility number: 0000 Residential Census: These State Resident accordance with 41000000000000000000000000000000000000	a need to implement checking in the Medication and ue to missing documentation. Alicy, titled "Charting and ted as last revised in July of from the Director of Nursing on indicated "The following documented in the resident dications ments or services State Residential Licensure icluded a Recertification and vey. Try 30, 31 and February 3, 4 20105 70 Itial Findings are cited in	R 000		Preparation and execution of the 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 plat of correction. In fact, this plan correction is submitted exclusive to comply with state and federal law. Marquette reserves the ritto challenge in legal proceedin all deficiencies, statements, findings, facts and conclusions that form the basis of the state deficiency. This plan of correct serves as the allegation of compliance. Marquette respectfully request desk review of the following ite	e an of vely al ght gs, d tion	

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ENTERSTOR	MEDICARE & MEDIC	AID SERVICES			OMB NO. 0938-039		
STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY			
AND PLAN OF CORRECTION IDENTIFICA		IDENTIFICATION NUMBER	A. BUILDING <u>00</u>		COMPLETED		
		155198	B. WING		02/05/2025		
	PROVIDER OR SUPPLIER	2	STREET ADDRESS, CITY, STATE, ZIP COD 8140 TOWNSHIP LINE RD				
MARQUE	EIIE		INDIAN	NAPOLIS, IN 46260			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRECTION	(X5)		
PREFIX	(EACH DEFICIENCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	COMPLETION		
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)	DATE		
R 0409 Bldg. 00	Infection Control - Noncompliance						
Ī		and record review, the facility	R 0409	I Residents #2 and	03/07/2025		
		dents had an annual health		#3 no longer reside in the			
		ted for 7 of 7 residents		community. Resident #4, Reside			
		arly health statements.		#5, Resident #6, Resident #7, ar	nd		
	(Resident 2, 3, 4, 5,	6, 7 and 8)		Resident #8 had no negative			
	Findings include:			consequences from the alleged deficient practice. It is the practic of Marquette to provide an annual			
	1 The clinical reco	rd for Recident 2 was reviewed		health statement in the resident's			
	1. The clinical record for Resident 2 was reviewed			medical record.	°		
	on 2/4/25 at 2:50 p.m. The diagnoses included, but were not limited to, muscle weakness, dysphagia			II All Assisted Living			
	(difficulty swallowing), and asthma.			residents have the potential to be			
				affected. Audit of resident's			
	An annual health st	atement was not found in the		medical records completed and			
	resident's record.	atement was not found in the		updated for all residents to include	40		
	resident's record.			the annual health statement.	ue		
	2 The clinical reco	rd for Resident 3 was reviewed		III The Tuberculosis (TB	,		
		m. The diagnoses included, but		Screening Policy for Residential	·		
		dysphagia, unsteadiness on		Care was reviewed and found to			
	feet, and a history of			meet clinical standards.			
				Education provided to all Assiste	ed be		
	An annual health st	atement was not found in the		Living Licensed Nursing Staff on			
	resident's record.			the Tuberculosis (TB) Screening			
				Policy for Residential Care			
	3. The clinical reco	rd for Resident 4 was reviewed		including verifying health			
		m. The diagnoses included, but		statement upon admission and			
		weakness, repeated falls, and		yearly. Additional systemic			
	anxiety.	, .		changes are being addressed			
				through our quality assurance			
	An annual health st	atement was not found in the		process described below.			
	resident's record.			1			
				IV The Assisted Living			
	4. The clinical reco	rd for Resident 5 was reviewed		Director or designee will:			
		m. The diagnoses included, but		Audit random sample of 20% of			
	-	dementia, rhabdomyolysis (a		residents' medical record to verif	fv		
		e tissue breaking down and		health statement weekly x 12	'		
	releasing its contents into the blood), and			weeks, then monthly for a total			

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weeks, then monthly for a total

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155198		A. BUILDING B. WING	G <u>00</u>	COMPLETED 02/05/2025				
NAME OF F	PROVIDER OR SUPPLIER	2	STREET ADDRESS, CITY, STATE, ZIP COD 8140 TOWNSHIP LINE RD					
MARQUETTE			IND	IANAPOLIS, IN 46260				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION		ID PREFIX TAG	CROSS-REFERENCED TO THE APPROPRI	(X5) COMPLETION DATE			
TAG	osteoarthritis. An annual health st resident's record. 5. The clinical record on 2/4/25 at 1:41 p. were not limited to, polyosteroarthritis (osteoarthritis). An annual health st resident's record. 6. The clinical record on 2/4/25 at 2:17 p. were not limited to, osteoporosis (a combones). An annual health st resident's record. 7. The clinical record on 2/4/25 at 1:57 p. were not limited to, fibrillation (an irregion chronic kidney disection in the stresident's record. During an interview Director of Assisted did not have the annual A current facility poscerening Policy for Admissions," undat	atement was not found in the rd for Resident 6 was reviewed m. The diagnoses included, but gout, vitamin d deficiency, and (multiple joints affected by atement was not found in the rd for Resident 7 was reviewed m. The diagnoses included, but insomnia, sleep apnea, and dition of weakening of the atement was not found in the rd for Resident 8 was reviewed m. The diagnoses included, but Parkinson's disease, atrial gular and rapid heartbeat), and ase. atement was not found in the rd, on 2/4/25 at 2:54 p.m., the d Living indicated the facility mual health statements. plicy, titled "Tuberculosis (TB) or Residential Care led and received from the	TAG		DATE and ts will cance ance anined e or and			
Director of Assisted Living indicated "A								

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AND PLAN OF CORRECTION IDENT		IDENTIFICATION NUMBER 155198	A. BUILDING 00 B. WING			COMPLETED 02/05/2025	
NAME OF PROVIDER OR SUPPLIER MARQUETTE			STREET ADDRESS, CITY, STATE, ZIP COD 8140 TOWNSHIP LINE RD INDIANAPOLIS, IN 46260				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION		ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPROPROPROPROPROPROPROPROPROPROPROPRO		TE	(X5) COMPLETION DATE	
		ide an annual statement resident is free from infectious					
R 0410	410 IAC 16.2-5-12						
Bldg. 00	Infection Control -	Noncompliance					
g	Based on interview and record review, the facility failed to ensure residents received a 2-step tuberculosis screening test when admitting to the facility for 2 of 7 residents reviewed for tuberculosis screening. (Residents 6 and 8) Findings include: 1. The clinical record for Resident 6 was reviewed on 2/4/25 at 1:41 p.m. The diagnoses included, but were not limited to, gout, vitamin D deficiency, and polyosteroarthritis.		R 0	410	I Residents #6 and Resident #8 had no negative consequences from the alleged deficient practice. It is the practice of Marquette to ensure 2-step tuberculosis screening is completed upon admission. II All residents have the potential to be affected. No residents have experienced any negative consequences from the alleged deficient practice.		03/07/2025
	The 2-step tubercule found in the chart. During an interview Director of Assisted was not able to find screening document 2. The clinical record on 2/4/25 at 2:00 p. were not limited to,	osis screening tests were not 7, on 2/4/25 at 1:49 p.m., the 1 Living indicated the facility the 2-step tuberculosis tation. rd for Resident 8 was reviewed m. The diagnoses included, but asthma, chronic obstructed (COPD), and Parkinson's			Screening Policy for Residential Care Policy was reviewed and found to meet clinical standards. Education provided to Assisted Living Licensed Nursing Staff Licensed on Tuberculosis (TB) Screening Policy for Residential Care Policy including 2-step tuberculosis screening for new admissions. Additional systemic changes are being addressed through our quality assurance process described below.		
	The resident admitted to the facility on 6/19/24. The 2-step tuberculosis screening tests were not found in the chart.				IV The Assisted Living Director or designee will: Audit all new admission medic record after admission to Assistant Living to verify tuberculosis	al	

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		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155198		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 02/05/2025		
NAME OF PROVIDER OR SUPPLIER MARQUETTE				STREET ADDRESS, CITY, STATE, ZIP COD 8140 TOWNSHIP LINE RD INDIANAPOLIS, IN 46260				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION		PRE	ID PROVIDERS PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROVIDENCY)		TE	(X5) COMPLETION DATE	
	During an interview, on 2/4/25 at 2:00 p.m., the Director of Assisted Living indicated the facility was not able to find the 2-step tuberculosis screening documentation. A current facility policy, titled "Tuberculosis (TB) Screening Policy for Residential Care Admissions," undated and received from the Director of Assisted Living indicated "All new residents must provide evidence of recent TB (tuberculosis) screening to safeguard the health of residents and staffPre-Admission RequirementsProvide documentation of a negative TB screeningcompleted within the last 30 daysIf no documentation is available, the facility will arrange a screening upon admissionResponsibilitiesFacility StaffEnsure TB screening compliance"					on of d s will ance ned and		

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