| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 155198 | A. BUILDING 00<br>B. WING | 02/05/2025 |

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

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| F 0000<br><br>Bldg. 00 | This visit was for a Recertification and State Licensure Survey. This visit included a State Residential Licensure Survey.<br><br>Survey dates: January 30, 31 and February 3, 4 and 5, 2025.<br><br>Facility number: 000105<br>Provider number: 155198<br><br>Census Bed Type:<br>SNF: 52<br>Residential: 70<br>Total: 122<br><br>Census Payor Type:<br>Medicare: 8<br>Other: 44<br>Total: 52<br><br>These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1.<br><br>Quality review was completed on February 7, 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 in legal proceedings, all deficiencies, statements, findings, facts and conclusions that form the basis of the stated deficiency. This plan of correction serves as the allegation of compliance.<br><br>Marquette respectfully requests a desk review of the following items: | |
| F 0582<br>SS=D<br>Bldg. 00 | 483.10(g)(17)(18)(i)-(v)<br>Medicaid/Medicare Coverage/Liability Notice<br><br>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 reviewed for beneficiary notification. (Resident 44) | F 0582 | I Resident #44 resides in the community and had no negative consequences from the alleged deficient practice. It is the practice of Marquette to provide NOMNOC and SNF ABN in a timely manner that adheres to policy, procedure and to State and | 03/07/2025 |

| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
|---|---|---|
| Jeffrey Cox | Administrator | 02/21/2025 |

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| | Findings include:<br><br>The NOMNOC and SNF ABN documents for Resident 44 were reviewed on 2/4/25 at 8:50 a.m.<br><br>a. The NOMNOC document indicated Resident 44's Medicare Part A coverage of services would end on 8/22/24 and Medicare would not pay for the current Medicare skilled services after the date of 8/22/24. The document indicated Resident 44 had the right to request an appeal. The appeal would need to be requested no later than noon of the day before the effective end of service date of 8/22/24.<br><br>Resident 44 was provided with the NOMNOC document on 9/9/24, 13 days after the end of service date.<br><br>b. The SNF ABN document indicated Resident 44's Medicare Part A Skilled coverage of services would end on 8/21/24 and beginning on 8/23/24, the services of Physical Therapy and Occupational Therapy would be out of pocket cost.<br><br>Resident 44 was provided with the SNF ABN document on 9/9/24, 15 days after the end of service date.<br><br>During an interview, on 2/3/25 at 9:09 a.m., the Social Service Director indicated therapy staff were "out of town" when Resident 44's beneficiary notices were due. The documents should have been provided to the resident 48 hours prior to the end of service date to give the resident time to appeal the decision.<br><br>A current facility policy, titled "Medicare Advance Beneficiary and Medicare | | Federal Guidelines and Regulations.<br>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 NOMNCs for residents who were discharged from the community were issued late.<br><br>III The Medicare Advance Beneficiary and Medicare Non-Coverage Notices Policy was reviewed by the Administrator and DON and found to meet clinical standards of care. The Director of Nurses provided education to the Social Services Coordinator on the timeframe for issuing NOMNC/ABN notices.<br><br>IV The IDT team and/or designee will:<br>Audit all NOMNC notice dates issued for discharged residents weekly in Medicare meetings. NOMNCs issued will be reviewed monthly during triple check meeting. Audits will be completed weekly for a total duration of 12 months. Additional audits will be completed based upon the level of compliance. 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 | |

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| | 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 bill...The facility issues the Skilled Nursing Facility Advance Beneficiary Notice (CMS form 10055) for the following triggering events...Termination-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 terminated...If 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...."<br><br>3.1-4(f)(1)(A)<br>3.1-4(f)(1)(B)<br>3.1-4(f)(2) | | compliance has been achieved as determined by the committee.<br><br>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. | |
| F 0583 SS=D Bldg. 00 | 483.10(h)(1)-(3)(i)(ii)<br>Personal Privacy/Confidentiality of Records<br><br>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)<br><br>Findings include:<br><br>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 |

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| | curtain had not been pulled to obscure the view of a visitor on the other side of the shared room. The visitor had an unobstructed view of the care being provided to Resident 19.<br><br>At that time, QMA 5 indicated the privacy curtain should have been closed when providing all care.<br><br>During an interview, on 2/4/25 at 3:19 p.m., the Director of Nursing indicated the facility followed the state and federal regulations.<br><br>A current facility policy, titled "Resident Rights," dated as revised in February 2021 and received from the Director of Nursing on 1/31/25 at 8:55 a.m., indicated "...Federal and state laws guarantee certain basic rights to all residents of this facility. These rights include the residents' right to...privacy and confidentiality...."<br><br>3.1-3(p)(2)<br>3.1-3(p)(4) | | II All residents have the potential to be affected. All licensed nursing staff and QMAs were educated on the Resident Rights Policy and the right to privacy while administering medications.<br><br>III The facility's policy on Resident Rights was reviewed and found to meet the clinical standards of practice. The Director of Nursing provided education to Health Center Licensed Nursing and QMA staff on Residents Rights and the right to privacy while providing care.<br><br>IV The Director of Nursing and/or designee will:<br>Conduct medication administration observations for privacy weekly x 12 weeks, then monthly for a total duration of 12 months. Results of the audits will be reported to the QAPI committee monthly. Additional audits will be completed based upon the level of compliance. The audits will be reviewed by Quality Assurance Committee until such time that consistent substantial compliance has been achieved as determined by the committee.<br><br>V The Administrator and Director of Nursing will be responsible for sustained compliance. The facility will be in | |

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| | | | and remain in compliance by March 7, 2025. | |
| F 0657 SS=D Bldg. 00 | 483.21(b)(2)(i)-(iii)<br>Care Plan Timing and Revision<br><br>Based on interview and record review, the facility failed to ensure care plan meetings were scheduled with the resident and/or resident's representative for 2 of 8 residents reviewed for care plan meetings. (Resident 36 and 37)<br><br>Findings include:<br><br>1. During an interview, on 1/30/25 at 10:33 a.m., a family member for Resident 36 indicated they had not attended a care plan meeting for a year.<br><br>The clinical record for Resident 36 was reviewed on 2/3/25 at 9:11 a.m. The diagnoses included, but were not limited to, severe dementia with mood disturbance, major depressive disorder, and mood disorder.<br><br>The last documented care plan meetings were held on 3/14/24 and 6/28/24.<br><br>2. During an interview, on 1/30/25 at 10:29 a.m., a family member for Resident 37 indicated they had not had a care plan meeting in a year.<br><br>The clinical record for Resident 37 was reviewed on 2/3/25 at 9:15 a.m. The diagnoses included, but were not limited to, age-related physical debility, constipation, and pain.<br><br>The last documented care plan meeting was held on 5/6/24.<br><br>During an interview, on 2/3/25 at 9:12 a.m., the | F 0657 | I Residents #36 and #37 had no negative consequences from the alleged deficient practice. Resident #36 and daughter attended care conference on February 7, 2025. Resident #37 and daughter invited to attend care conference on February 3, 2025, invitation declined, and record updated. It is the practice of Marquette to ensure care planning meetings are scheduled with the resident and/or resident representative.<br><br>II All residents have the potential to be affected. An audit has been conducted for all residents' medical records for the past 3 months to ensure residents and residents' representatives have been provided with the opportunity to participate in the residents' care planning. Any discrepancies have been corrected with the offer of a care plan meeting.<br><br>III The Care Planning Policy was reviewed by the Administrator and Director of Nursing and found to meet clinical standards.<br>Education provided to Social | 03/07/2025 |

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| | Social Services Worker indicated care plan conferences were to be completed quarterly and a note was to be put into the medical record.<br><br>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 told her everything was "o.k." or if they did not want a care plan meeting then she did not schedule a meeting. She was aware that a care plan meeting needed to be done, and the invite to the meeting needed to be sent to the responsible party/Power of Attorney and the resident. If they did not want to attend, she was to document the information.<br><br>During an interview, on 2/4/25 at 3:19 p.m., the Director of Nursing indicated the facility followed the state and federal regulations.<br><br>A current facility policy, titled "Care Planning," dated as revised in March 2022 and received from the Executive Director on 2/3/25 at 1:34 p.m., indicated "...The interdisciplinary team is responsible for the development of the resident care plans...."<br><br>3.1-35(a)<br>3.1-35(d)(2)(B) | | Services Coordinator on Care Planning Policy, including education on updating medical records with explanation for declined meeting.<br><br>IV The Social Service Coordinator and/or designee will: Conduct care plan meeting audit of current residents weekly for 8 weeks, then every other week for 8 weeks, then monthly for a total duration of 12 months. Results of the audits will be reported to the QAPI committee monthly. Additional audits will be completed based upon the level of compliance. The audits will be reviewed by Quality Assurance Committee until such time that consistent substantial compliance has been achieved as determined by the committee.<br>V. The Administrator and Social Service Coordinator will be responsible for sustained compliance. The facility will be in and remain in compliance by March 7, 2025. | |
| F 0684<br>SS=D<br>Bldg. 00 | 483.25<br>Quality of Care<br><br>Based on interview and record review, the facility failed to ensure the physician was notified when blood sugars were out of the physician ordered parameters for 1 of 1 resident reviewed for quality of care. (Resident 34) | F 0684 | I Resident #34 had no negative consequences from the alleged deficient practice. It is the practice of Marquette to notify the physician of blood sugars outside of parameter range per the | 03/07/2025 |

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| | Findings include:<br><br>The clinical record for Resident 34 was reviewed on 2/3/25 at 1:32 p.m. The diagnoses included, but were not limited to, type 2 diabetes, edema, and chronic kidney disease.<br><br>A physician's order, dated 7/8/24, indicated to obtain Accu Checks (blood sugar checks) 4 times a day and to call the physician when the blood sugars were less than 70 or greater than 400.<br><br>A review of Resident 34's blood sugars indicated the following results:<br>On 12/18/24, the resident's blood sugar was 69.<br>On 12/28/24, the resident's blood sugar was 65.<br>On 12/28/24, the resident's blood sugar was 425.<br>On 1/5/25, the resident's blood sugar was 51.<br><br>There was no documentation the physician was notified of the blood sugars which were out of the physician ordered parameters found in the resident's record.<br><br>During an interview, on 2/4/25 at 3:18 p.m., the Director of Nursing (DON) indicated she could not find any notification for the blood sugars and the nurse should have notified the physician.<br><br>During an interview, on 2/5/25 at 11:09 a.m., the DON indicated she could not find any notifications for the blood sugars in the record.<br><br>A current facility policy, titled "Charting and Documentation," dated as revised in 2017 and received from the DON on 2/4/25 at 3:17 p.m., indicated "...Documentation of procedures and treatments will include care-specific details, including...notification of family, physician or other staff, if indicated...." | | physician's orders.<br>II All residents with an order for blood sugar checks have the potential to be affected.<br>An audit has been conducted of all residents with blood check orders for blood sugars outside of physician ordered parameters in the past 30 days for physician notification and documentation. Any discrepancies have been corrected.<br>III The Charting and Documentation Policy reviewed and found to meet clinical standards.<br>Education provided to Health Center Licensed Nursing staff on Charting and Documentation Policy including following physician's order for blood sugar parameters, physician notification, and documentation. Additional systemic changes are being addressed through our quality assurance process described below.<br><br>IV The Director of Nursing or designee will:<br>Audit all resident blood sugars for results out of physician parameters and notification of provider, three times weekly for 8 weeks, then weekly for 8 weeks, then monthly for a total duration of 12 months. Results of all audits will be brought to QAPI for review and revision as needed. The audits will be reviewed by Quality | |

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| | 3.1-37(a) | | Assurance Committee until such time consistent substantial compliance has been achieved as determined by the committee. This will be submitted to QAPI monthly for review.<br><br>V The Administrator and Director of Nursing will be responsible for sustained compliance. The facility will be in and remain in compliance by March 7, 2025. | |
| F 0692 SS=D Bldg. 00 | 483.25(g)(1)-(3)<br>Nutrition/Hydration Status Maintenance<br><br>Based on interview and record review, the facility failed to ensure staff obtained a resident's weight weekly to monitor for weight loss according to the physician's order and to correctly document the weights in the medical record for 1 of 3 residents reviewed for nutrition. (Resident 8)<br><br>Findings include:<br><br>The clinical record for Resident 8 was reviewed on 2/4/25 at 1:29 p.m. The diagnoses included, but were not limited to, Barrette's esophagus, anorexia, and nutritional deficiency.<br><br>A nutritional note, dated 9/12/24, indicated the Registered Dietitian (RD) recommended to begin weekly weights for closer weight loss monitoring.<br><br>A progress note, dated 9/12/24, indicated a new order had been placed for weekly weights.<br><br>A physician's order indicated Resident 8 was to be weighed weekly in the morning, every | F 0692 | I Resident #8 had no negative consequences from the alleged deficient practice. It is the practice of Marquette to obtain weekly weights and correctly document according to physician's order.<br>II All residents with an order for weekly weights have the potential to be affected.<br>An audit has been conducted of all residents with an order for weekly weights for accurate documentation. Any discrepancies have been corrected.<br>III The Nutrition Risk and Weight Loss Management and Charting and Documentation Policy has been reviewed and found to meet clinical standards.<br>Education provided to Health Center Nursing staff on Nutrition Risk and Weight Loss | 03/07/2025 |

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| | Monday, for weight loss starting 9/16/24.<br><br>A nutritional note, dated 11/7/24, indicated the RD would continue weekly weights for closer monitoring and would follow up with Resident 8's intakes, weekly weights, and labs as available.<br><br>The resident's medical record was missing documentation for the weekly weights in the months of September, November, January, and February.<br><br>A review of a weight summary indicated that the facility did not obtain weekly weights in the months of September, November, December, January, and February.<br><br>During an interview, on 2/4/25 at 2:21 p.m., Licensed Practical Nurse 4 indicated when a resident had an order for weekly weights, the weights were documented on a form kept at the nurse's station and given to the unit manager when completed.<br><br>During an interview, on 2/4/25 at 2:24 p.m., the Assistant Director of Nursing (ADON) indicated the weekly weight order should have been discontinued because Resident 8 was no longer followed by the RD.<br><br>During an interview, on 2/4/25 at 3:18 p.m., the Director of Nursing (DON) indicated the resident 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 the order for the weekly weights. The order remained active, and the weights should have | | Management and Charting and Documentation Policy including documentation of weight in medical record. Additional systemic changes are being addressed through our quality assurance process described below.<br><br>IV The Director of Nursing or designee will:<br>Audit of all weekly weights for documentation in medical record weekly x 12 weeks, then monthly for a total duration of 12 months. Results of all audits will be brought to QAPI for review and revision as needed. The audits will be reviewed by Quality Assurance Committee until such time consistent substantial compliance has been achieved as determined by the committee. This will be submitted to QAPI monthly for review.<br><br>V The Administrator and Director of Nursing will be responsible for sustained compliance. The facility will be in and remain in compliance by March 7, 2025. | |

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| | continued to be obtained according to the order.<br><br>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.<br><br>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 policy...Residents 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...."<br><br>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 objective...complete, and accurate...."<br><br>3.1-46(a)(1) | | | |
| F 0695 SS=D Bldg. 00 | 483.25(i)<br>Respiratory/Tracheostomy Care and Suctioning<br>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 community and according to the O2 sats recorded Resident #10 was not affected by this alleged deficient practice. Resident physician order | 03/07/2025 |

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| | Findings include:<br><br>During an observation, on 1/31/25 at 9:58 a.m., Resident 10's oxygen flow rate was on 2-liters.<br><br>The clinical record for Resident 10 was reviewed on 2/3/25 at 1:30 p.m. The diagnoses included, but were not limited to, chronic obstructed pulmonary disease (COPD), chronic respiratory failure, and essential hypertension.<br><br>A physician's order, dated 1/8/25, indicated the oxygen flow rate was to be at 4 liters per minute via nasal cannula. The order summary indicated the oxygen flow rate was to be at 2 liters per minute via nasal cannula.<br><br>The order had 2 different oxygen liter flow rates.<br><br>During an interview, on 2/3/25 at 1:48 p.m., Licensed Practical Nurse (LPN) 3 indicated the oxygen order was not a titration order. She thought the resident was to be on 4 liters but did not see the 2 liters listed in the order summary. She would have to clarify the order because she was not sure.<br><br>During an interview, on 2/3/25 at 1:55 p.m., the Director of Nursing (DON) indicated she was not sure what the oxygen flow rate was supposed to be, and she would have to check.<br><br>During an interview, on 2/3/25 at 2:11 p.m., the DON indicated Resident 10 was supposed to be on 4 liters of oxygen.<br><br>A facility policy, titled "Oxygen Administration," dated as revised in October 2010 and received from the DON on 2/4/25 at 3:20 p.m., indicated "...Turn on the oxygen. Unless otherwise ordered, | | was reviewed and updated. The DON and Charge Nurse responsible for the residents' care observed and verified that the liter flow was set per MD order. It is the practice of Marquette to ensure physician's oxygen orders have a clear and accurate oxygen liter flow rate.<br>II All residents who utilize oxygen could be affected by this alleged deficient practice. Physician order review and observation of liter flow was completed on all residents who utilize oxygen, and all were found in compliance.<br><br>III The Oxygen Administration Policy was reviewed and found to meet clinical standards. Education provided to Health Center Licensed Nursing Staff on the Oxygen Administration Policy including verification of the oxygen physician order against liter flow. Additional systemic changes are being addressed through our quality assurance process described below.<br><br>IV The Director of Nursing or designee will:<br>Audit of compliance of oxygen orders and liter flow rates up to 5 residents utilizing oxygen three times weekly for 8 weeks, then weekly for 8 weeks, then monthly for a total duration of 12 months. | |

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| | start the flow of oxygen at the rate per physician order...."<br><br>3.1-47(a)(6) | | 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. This will be submitted to QAPI monthly for review.<br><br>V The Administrator and Director of Nursing will be responsible for sustained compliance. The facility will be in and remain in compliance by March 7, 2025. | |
| F 0810 SS=D Bldg. 00 | 483.60(g)<br>Assistive Devices - Eating Equipment/Utensils<br>Based on observation, interview and record review, the facility failed to ensure a two (2) handle cup was available for a resident's coffee for 1 of 1 resident reviewed for adaptive equipment. (Resident 1)<br><br>Findings include:<br><br>During an observation of the morning meal, on 2/3/25 at 8:35 a.m., Resident 1 was observed in the dining room. She had two handle cups for her milk, juice and water with lids, but an insulated cup with only one handle for coffee.<br><br>During an interview, on 2/3/25 at 8:25 a.m., the Dietary Manager (DM) indicated she was aware the resident needed two (2) handle cups for her drinks, but she did not think about the coffee and the facility did not have a two-handle insulated | F 0810 | I Resident #1 no longer resides in the community and was not negatively affected by this alleged deficient practice. Two handled insulated cups were ordered and delivered to the facility. It is the practice of Marquette to ensure two handled cups are available.<br>II All residents requiring a two handled cups have the potential to be affected by the alleged deficient practice. Care plans and Kardex for all residents who require assistance with consuming fluids in a two handled cups were reviewed and updated as applicable. | 03/07/2025 |

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| | cup. The therapy department indicated the resident needed two handle cups to hold the cup better. She would need to talk with management because the facility would need to order the cup.<br><br>During an observation, on 2/5/25 at 8:33 a.m., Resident 1 was in the dining room eating her meal without assistance. She was noted to have milk, juice and water in two handle cups, but no coffee.<br><br>During an interview, on 2/5/25 at 8:33 a.m., the Dietary Manager indicated Resident 1 did not have coffee because the facility did not have insulated cups with two handles and coffee could not be put in the regular two handle cups because the heat from the coffee could be felt through the cups.<br><br>The clinical record for Resident 1 was reviewed on 2/5/25 at 8:53 a.m. The diagnoses included, but were not limited to, weakness, heart failure, and a need for assistance with personal care.<br><br>A care plan, initiated on 12/5/24 and dated as last revised on 2/3/25, indicated the resident was at a nutritional risk and she was to use adaptive equipment to assist with feeding herself.<br><br>A facility document, titled "Occupational Therapy Treatment Encounter Note(s)," with a date of service of 1/2/25 indicated an order was written for two handle mugs with lids to increase the resident's independence, oral intake, and to decrease spillage.<br><br>A physician's order, initiated on 1/31/25, indicated 2 handle mugs with all meals.<br><br>During an interview, on 2/4/25 at 1:06 p.m., the Therapy Manager indicated the resident was | | III The Activities of Daily Living, Supporting Policy was reviewed and found to meet clinical standards. Education provided to Health Center Nursing Staff and Dietary on the ADL Support Policy including providing two handled cups. Additional systemic changes are being addressed through our quality assurance process described below.<br><br>IV The Director of Nursing or designee will:<br>Audit/observe residents who require two handled cups at random meals three times weekly for 8 weeks, then weekly for 8 weeks, then monthly for a total duration of 12 months. Results of all audits will be brought to QAPI for review and revision as needed. The audits will be reviewed by Quality Assurance Committee until such time consistent substantial compliance has been achieved as determined by the committee. This will be submitted to QAPI monthly for review.<br><br>V The Administrator, Director of Nursing and Dietary Manager will be responsible for sustained compliance. The facility will be in and remain in compliance by March 7, 2025. | |

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| | using two handle cups to promote independence with activities of daily living (basic self-care tasks performed daily such as eating). The resident was currently using two handle cups with no lids when she was discharged from therapy.<br><br>A current facility policy, titled "Activities of Daily Living (ADLs), Supporting," dated as revised in March 2018 and received from the Director of Nursing on 2/4/25 at 3:19 p.m., indicated "...Residents will be provided with care, treatment and services to ensure that their activities of daily living (ADLs) do not diminish...."<br><br>3.1-21(h) | | | |
| F 0842 SS=D Bldg. 00 | 483.20(f)(5), 483.70(i)(1)-(5)<br>Resident Records - Identifiable Information<br><br>Based on interview and record review, the facility failed to ensure documentation was complete and accurately reflected the care provided for 2 of 2 residents reviewed for accurate documentation. (Resident 46 and 1)<br><br>Findings include:<br><br>1. The clinical record for Resident 46 was reviewed on 2/5/25 at 10:19 a.m. The diagnoses included, but were not limited to, insomnia, chronic kidney disease, and fever.<br><br>A physician's order, initiated on 1/3/25, indicated to give Dayvigo (a medication used to treat insomnia) 10 milligrams at bedtime for insomnia. Documentation of the administration of the medication was not charted on 1/10/25 and 1/25/25.<br><br>A physician's order, initiated on 1/3/25, indicated | F 0842 | I Resident #1 no longer resides in the community. Resident #46 and Resident #1 had no negative consequences from the alleged deficient practice. It is the practice of Marquette to ensure documentation is completed and accurate to reflect care provided.<br>II All residents have the potential to be affected. No residents experienced any negative consequences from the alleged deficient practice.<br>III The Charting and Documentation Policy was reviewed and found to meet clinical standards. Education provided to Health Center Licensed Nursing Staff on Charting and Documentation Policy | 03/07/2025 |

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| | to monitor the resident's vital signs twice a day. Documentation of the treatment was not charted on the Medication and Treatment record for 1/31/25 for the second shift.<br><br>2. The clinical record for Resident 1 was reviewed on 2/5/25 at 8:53 a.m. The diagnoses included, but were not limited to, weakness, heart failure, and a need for assistance with personal care.<br><br>A physician's order, initiated on 11/29/24, indicated to monitor for signs and symptoms of side effects from psychoactive drugs every shift and to notify the physician if side effects were present. There was no documentation for the monitoring found in the MAR/TAR for 12/5/24, 12/11/24 or 12/18/24 for the evening shift.<br><br>A physician's order, initiated on 11/29/24, indicated to monitor for signs and symptoms of anti-coagulant medications (used to thin the blood) every shift. There was no documentation for the monitoring found in the MAR/TAR for 12/5/24, 12/11/24 or 12/18/24 for the evening shift.<br><br>A physician's order, initiated on 11/29/24, indicated to assess the resident for pain every shift. There was no documentation for the assessment found in the MAR/TAR for 12/5/24, 12/11/24 or 12/18/24 for the evening shift.<br><br>A physician's order indicated the resident was to be weight bearing (standing/walking) as tolerated on her bilateral lower extremities every shift. There was no documentation for the monitoring found in the MAR/TAR for 12/5/24, 12/11/24 or 12/18/24 for the evening shift.<br><br>During an interview, on 2/5/25 at 9:19 a.m., the Assistant Director of Nursing indicated the | | including importance of timely documentation Additional systemic changes are being addressed through our quality assurance process described below.<br><br>IV The Director of Nursing or designee will:<br>Audit 20% of residents for completed Medication and Treatment Administration Record documentation, three times weekly for 8 weeks, then weekly for 8 weeks, then monthly for a total duration of 12 months. Results of all audits will be brought to QAPI for review and revision as needed. The audits will be reviewed by Quality Assurance Committee until such time consistent substantial compliance has been achieved as determined by the committee. This will be submitted to QAPI monthly for review.<br><br>V The Administrator and Director of Nursing will be responsible for sustained compliance. The facility will be in and remain in compliance by March 7, 2025. | |

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| | facility determined a need to implement checking the documentation in the Medication and Treatment records due to missing documentation.<br><br>A current facility policy, titled "Charting and Documentation," dated as last revised in July of 2017 and received from the Director of Nursing on 2/4/25 at 3:17 p.m., indicated "...The following information is to be documented in the resident medical record...Medications administered...Treatments or services preformed...."<br><br>3.1-50(a)(1)<br>3.1-50(a)(2) | | | |
| R 0000<br><br>Bldg. 00 | This visit was for a State Residential Licensure Survey. This visit included a Recertification and State Licensure Survey.<br><br>Survey dates: January 30, 31 and February 3, 4 and 5, 2025.<br><br>Facility number: 000105<br><br>Residential Census: 70<br><br>These State Residential Findings are cited in accordance with 410 IAC 16.2-5.<br><br>Quality review was completed on February 7, 2025. | R 0000 | Preparation and execution of this plan of correction in no way constitutes an admission or agreement by Marquette of the truth of the facts alleged in this statement of deficiency and plan of correction. In fact, this plan of correction is submitted exclusively to comply with state and federal law. Marquette reserves the right to challenge in legal proceedings, all deficiencies, statements, findings, facts and conclusions that form the basis of the stated deficiency. This plan of correction serves as the allegation of compliance.<br><br>Marquette respectfully requests a desk review of the following items: | |

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| R 0409<br><br>Bldg. 00 | 410 IAC 16.2-5-12(d)<br>Infection Control - Noncompliance<br><br>Based on interview and record review, the facility failed to ensure residents had an annual health statement documented for 7 of 7 residents reviewed for the yearly health statements. (Resident 2, 3, 4, 5, 6, 7 and 8)<br><br>Findings include:<br><br>1. The clinical record for Resident 2 was reviewed on 2/4/25 at 2:50 p.m. The diagnoses included, but were not limited to, muscle weakness, dysphagia (difficulty swallowing), and asthma.<br><br>An annual health statement was not found in the resident's record.<br><br>2. The clinical record for Resident 3 was reviewed on 2/4/25 at 3:03 p.m. The diagnoses included, but were not limited to, dysphagia, unsteadiness on feet, and a history of stroke.<br><br>An annual health statement was not found in the resident's record.<br><br>3. The clinical record for Resident 4 was reviewed on 2/4/25 at 1:05 p.m. The diagnoses included, but were not limited to, weakness, repeated falls, and anxiety.<br><br>An annual health statement was not found in the resident's record.<br><br>4. The clinical record for Resident 5 was reviewed on 2/4/25 at 2:34 p.m. The diagnoses included, but were not limited to, dementia, rhabdomyolysis (a condition of muscle tissue breaking down and releasing its contents into the blood), and | R 0409 | I Residents #2 and #3 no longer reside in the community. Resident #4, Resident #5, Resident #6, Resident #7, and Resident #8 had no negative consequences from the alleged deficient practice. It is the practice of Marquette to provide an annual health statement in the resident's medical record.<br>II All Assisted Living residents have the potential to be affected. Audit of resident's medical records completed and updated for all residents to include the annual health statement.<br>III The Tuberculosis (TB) Screening Policy for Residential Care was reviewed and found to meet clinical standards. Education provided to all Assisted Living Licensed Nursing Staff on the Tuberculosis (TB) Screening Policy for Residential Care including verifying health statement upon admission and yearly. Additional systemic changes are being addressed through our quality assurance process described below.<br><br>IV The Assisted Living Director or designee will: Audit random sample of 20% of residents' medical record to verify health statement weekly x 12 weeks, then monthly for a total | 03/07/2025 |

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| | osteoarthritis.<br><br>An annual health statement was not found in the resident's record.<br><br>5. 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 (multiple joints affected by osteoarthritis).<br><br>An annual health statement was not found in the resident's record.<br><br>6. The clinical record for Resident 7 was reviewed on 2/4/25 at 2:17 p.m. The diagnoses included, but were not limited to, insomnia, sleep apnea, and osteoporosis (a condition of weakening of the bones).<br><br>An annual health statement was not found in the resident's record.<br><br>7. The clinical record for Resident 8 was reviewed on 2/4/25 at 1:57 p.m. The diagnoses included, but were not limited to, Parkinson's disease, atrial fibrillation (an irregular and rapid heartbeat), and chronic kidney disease.<br><br>An annual health statement was not found in the resident's record.<br><br>During an interview, on 2/4/25 at 2:54 p.m., the Director of Assisted Living indicated the facility did not have the annual health statements.<br><br>A current facility policy, titled "Tuberculosis (TB) Screening Policy for Residential Care Admissions," undated and received from the Director of Assisted Living indicated "...A | | duration of 12 months.<br>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. This will be submitted to QAPI monthly for review.<br>V The Administrator and Assisted Living Director will be responsible for sustained compliance. The facility will be in and remain in compliance by March 7, 2025. | |

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| | physician will provide an annual statement confirming that the resident is free from infectious disease...."<br><br>410 IAC 16.2-5-12(e)(f)(g)<br>Infection Control - Noncompliance | | | |
| R 0410<br><br>Bldg. 00 | 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)<br><br>Findings include:<br><br>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.<br><br>The resident admitted to the facility on 1/31/24.<br><br>The 2-step tuberculosis screening tests were not found in the chart.<br><br>During an interview, on 2/4/25 at 1:49 p.m., the Director of Assisted Living indicated the facility was not able to find the 2-step tuberculosis screening documentation.<br><br>2. The clinical record for Resident 8 was reviewed on 2/4/25 at 2:00 p.m. The diagnoses included, but were not limited to, asthma, chronic obstructed pulmonary disease (COPD), and Parkinson's disease.<br><br>The resident admitted to the facility on 6/19/24.<br><br>The 2-step tuberculosis screening tests were not found in the chart. | R 0410 | 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.<br>II All residents have the potential to be affected. No residents have experienced any negative consequences from the alleged deficient practice.<br><br>III The Tuberculosis (TB) 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.<br><br>IV The Assisted Living Director or designee will:<br>Audit all new admission medical record after admission to Assisted Living to verify tuberculosis | 03/07/2025 |

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| | 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.<br><br>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 staff...Pre-Admission Requirements...Provide documentation of a negative TB screening...completed within the last 30 days...If no documentation is available, the facility will arrange a screening upon admission...Responsibilities...Facility Staff...Ensure TB screening compliance...." | | screening, daily after admission has occurred for a total duration of 12 months.<br>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. This will be submitted to QAPI monthly for review.<br>V The Administrator and Assisted Living Director will be responsible for sustained compliance. The facility will be in and remain in compliance by March 7, 2025. | |