STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155198	A. BUILDING -- B. WING	02/25/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
MARQUETTE	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 PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 0000 Bldg. --	An Emergency Preparedness Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.73. Survey Date: 02/25/25 Facility Number: 000105 Provider Number: 155198 AIM Number: N/A At this Emergency Preparedness survey, Marquette was found in compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 483.73. The facility has 57 certified beds. At the time of the survey, the census was 54. Quality Review completed on 02/27/25	E 0000		
K 0000 Bldg. 01	A Life Safety Code Recertification and State Licensure Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.90(a). Survey Date: 02/25/25 Facility Number: 000105 Provider Number: 155198 AIM Number: N/A At this Life Safety Code survey, Marquette was found not in compliance with Requirements for	K 0000	The preparation and implementation of this plan of correction does not constitute an admission or agreement by Marquette regarding the accuracy of the facts alleged in this statement of deficiencies and plan of correction. Rather, this plan is submitted solely to comply with state and federal requirements. Marquette reserves the right to contest, through legal proceedings, any deficiencies,	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Jeffrey Cox	Administrator	03/13/2025

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	Participation in Medicare, 42 CFR Subpart 483.90(a), Life Safety from Fire and the 2012 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19, Existing Health Care Occupancies and 410 IAC 16.2. This two-story building with a basement was determined to be of Type II (222) construction and was fully sprinklered. The facility has a fire alarm system with smoke detection in the corridor and in all areas open to the corridor. The facility has smoke detectors hard wired to the fire alarm system installed in all resident sleeping rooms. The facility has a capacity of 57 and had a census of 54 at the time of this survey. All areas where residents have customary access were sprinklered. All areas providing facility services were sprinklered. Quality Review completed on 02/27/25		statements, findings, facts, or conclusions underlying the cited deficiency. This plan of correction serves as an allegation of compliance. Marquette respectfully requests a desk review of the following items:	
K 0321 SS=E Bldg. 01	NFPA 101 Hazardous Areas - Enclosure Based on observation and interview, the facility failed to ensure the corridor door to 1 of 6 hazardous areas, such as combustible storage rooms over 50 square feet, soiled linen rooms, and boiler rooms, were provided with self-closing devices which would cause the doors to automatically close and latch into the door frames or provided with smoke resistant partitions. This deficient practice could affect 14 residents, 4 staff and 2 visitors. Findings include: Based on observations made on 03/25/25 during a	K 0321	**1. What corrective action will be accomplished for those residents found to have been affected by the deficient practice?** No residents were directly affected by this deficiency. However, immediately following the survey, a hinge spring **self-closing device** was installed on the medical records storage room door to ensure compliance with NFPA 101 requirements for hazardous areas.	03/25/2025

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	tour of the facility at 11:55 a.m. with the Health Care Administrator, the medical records storage room on the second floor had numerous boxes and loose medical records stored throughout the room. This room measured approximately 20 feet by 12 feet and contained enough combustible files and storage to be considered a hazardous room. Also, corridor door to the medical records storage room did not have a self-closing device attached to it. Based on an interview at the time of the observation, the Health Care Administrator advised he would have a self-closing device or hinge spring self-closer added to the door as soon as possible. This item was discussed again with the Health Care Administrator at the exit conference on 02/25/25. 3.1-19(b)		**2. How will other residents having the potential to be affected by the same deficient practice be identified, and what corrective action will be taken?** 14 residents, 4 staff, and 2 visitors could potentially be impacted by the alleged deficient practice. Immediately following the survey, a hinge spring self-closing device was installed on the identified door -compliant with NFPA 101. **3. What measures will be put into place, or what systemic changes will be made to ensure that the deficient practice does not recur?** ·The following systemic changes will be implemented to ensure that the alleged deficient practice does not recur: ·A hinge spring self-closing device has been installed on the identified door. ·Facility management will implement a Hazardous Area Storage and Safety Compliance Policy that complies Life Safety Code (NFPA 101) - see attached. ·Education/in-service training will be provided to facility Health Center Plant staff highlighting the requirements for NFPA 101 – Hazardous Areas – Enclosure. Including proper storage and door compliance (see attached). ·The **Plant Director or designee** will inspect the identified hazardous storage area	

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			to ensure compliance with Life Safety Code regulations (see below for details). **4. How will the corrective action be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?** ·The **Plant Director or designee** will conduct and document **audit inspections** of the identified hazardous storage area, ensuring that the hinge spring self-closing device on the door is operational. ·These audits will occur weekly for four weeks, bi-weekly for four weeks, and then monthly for a total duration of six months. ·Findings will be reviewed in the facility's **Quality Assurance and Performance Improvement meeting** to ensure ongoing compliance. ·Any non-compliance issues will be addressed immediately, and retraining will be provided as needed. **5. Compliance Date: 3/25/25**	
K 0324 SS=E Bldg. 01	NFPA 101 Cooking Facilities Based on observation and interview, the facility failed to provide an approved method for returning cooking appliances to where they were when the kitchen hood extinguishing equipment was designed and installed for 1 of 1 kitchen hood extinguishing system. NFPA 96, Standard for	K 0324	**1. What corrective action will be accomplished for those residents found to have been affected by the deficient practice?** No residents were affected by the	03/25/2025

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	Ventilation Control and Fire Protection of Commercial Cooking Operations Section 2011 Edition Section 12.1.2.2, states cooking appliances requiring protection shall not be moved, modified, or rearranged without prior re-evaluation of the fire-extinguishing system by the system installer or servicing agent, unless otherwise allowed by the design of the fire extinguishing system. Section 12.1.2.3 states the fire-extinguishing system shall not require reevaluation where the cooking appliances are moved for the purposes of maintenance and cleaning, provided the appliances are returned to approved design location prior to cooking operations, and any disconnected fire-extinguishing system nozzles attached to the appliances are reconnected in accordance with the manufacturer's listed design manual. Section 12.1.2.3.1 states an approved method shall be provided that will ensure that the appliance is returned to an approved design location. The deficient practice could affect as many as 22 residents, 6 staff, and 2 visitors in the facility. Findings include: Based on observations made during a tour of the facility with the Health Care Administrator on 02/25/25 at 12:08 p.m., the six (6) burner stove and the flat grill which was located on the cooking line under the hood in the kitchen was not provided with an approved method that would ensure that the appliance was returned to an approved design location after it had been moved for maintenance and/or cleaning. Based on interview at the time of the observation, the Health Care Administrator stated that he was not aware an approved method should be provided to ensure that the appliance was returned to an approved design location after maintenance or cleaning and that he would have		alleged deficient practice. However, to ensure compliance and safety, the facility has installed an **approved appliance positioning system** (floor-mounted positioning device) to guarantee that the six-burner stove and flat grill are always returned to their designated locations under the hood suppression system after cleaning or maintenance. **2. How will other residents having the potential to be affected by the same deficient practice be identified, and what corrective action will be taken?** This alleged deficient practice could affect as many as 22 residents, 6 staff, and 2 visitors in the event of a fire. To prevent this risk: ·A **review** of all commercial cooking equipment under fire suppression systems was conducted to verify compliance. ·The kitchen appliances requiring designated placement have been assessed, and corrective measures have been taken where necessary – including the installation of approved appliance positioning systems (see attached image of corrective measures). **3. What measures will be put into place, or what systemic changes will be made to ensure that the deficient**	

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	something done to the kitchen stove or floor to meet code compliance as soon as possible. This item was discussed again with the Health Care Administrator at the exit conference on 02/25/25. 3.1-19(b)		**practice does not recur?** ·The following systemic changes will be implemented to ensure that the alleged deficient practice does not recur: The facility has installed an approved appliance positioning system (floor-mounted positioning device) to guarantee that the six-burner stove and flat grill are always returned to their designated locations under the hood suppression system following movement (cleaning/maintenance). ·Facility management will implement a **Cooking Equipment Safety and Compliance Policy** that complies with Life Safety Code (NFPA 96/101) - see attached. ·Education/in-service training will be provided to facility Health Center Plant and Kitchen staff highlighting the requirements for NFPA 101 – Cooking Facilities. Including proper equipment placement, and how to confirm that appliances are in their correct positions before cooking operations occur. ·The **Plant Director or designee** will routinely inspect the identified cooking facility to ensure the appliance positioning systems are in working order and in-compliance with Life Safety Code regulations (see below for details). **4. How will the corrective**	

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			action be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place? ·The **Plant Director** or designee will conduct audit **inspections** of kitchen equipment placement and ensure compliance with Life Safety standards. ·This audit will occur weekly for four weeks, bi-weekly for four weeks, and then monthly for a total duration of six months. ·An audit **checklist** has been implemented for staff to verify proper appliance positioning after each cleaning or maintenance session (see attached). ·Compliance will be reviewed in the facility's **Quality Assurance and Performance Improvement Meeting**, and any issues will be addressed immediately with additional training or corrective actions. **5. Compliance Date: 3/25/25**	
K 0351 SS=E Bldg. 01	NFPA 101 Sprinkler System - Installation Based on observation and interview, the facility failed to maintain the ceiling construction in 1 of 1 central supply office in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems. NFPA 13, 2010 edition, Section 6.2.7.1 states plates, escutcheons, or other devices used to cover the annular space around a sprinkler shall be metallic, or shall be listed for use around a sprinkler. This deficient practice could affect staff	K 0351	**1. What corrective action will be accomplished for those residents found to have been affected by the deficient practice?** No residents were affected by the alleged deficiency. However, the escutcheon around the sprinkler head was immediately repaired,	03/25/2025

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	and up to 1 resident, 2 staff and 1 visitor. Findings include: Based on observations with the Health Care Administrator on 02/25/25 at 11:17 p.m., the central supply office had a loose escutcheon with approximately one-quarter inch gap of annular space around the sprinkler head. Based on interview at the time of observation, the Health Care Administrator acknowledged the annular space at the escutcheon, had given the aforementioned measurement, and called a maintenance man to look into fixing the escutcheon as soon as possible. This item was discussed again with the Health Care Administrator at the exit conference on 02/25/25. 3.1-19(b)		ensuring the annular space around the sprinkler head is correctly sealed in compliance with NFPA 13 standards. **2. How will other residents having the potential to be affected by the same deficient practice be identified, and what corrective action will be taken?** 1 resident, 2 staff, and 1 visitor in the facility could potentially be impacted if the identified fire suppression system is not functioning correctly. To ensure safety: ·The identified deficiency was corrected immediately to meet the standards set by NFPA 13. The escutcheon identified during the survey has been repaired (see attached image). ·A **facility-wide inspection** will be conducted to check all sprinkler heads for any gaps or improperly fitted escutcheons. **3. What measures will be put into place, or what systemic changes will be made to ensure that the deficient practice does not recur?** ·The following systemic changes will be implemented to ensure that the alleged deficient practice does not recur: ·The escutcheon identified during the survey has been repaired (see attached image). ·**Education/in-service training** will be provided to **Health**	

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			Center Plant staff highlighting NFPA 13 standards, particularly focusing on the community's policy for ensuring proper installation and maintenance of sprinkler system escutcheons. ·The **Plant Director or designee** will routinely audit/inspect sprinkler heads and escutcheon's throughout facility to ensure compliance with Life Safety Code regulations (see below for details). **4. How will the corrective action be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?** ·The **Plant Director or designee** will conduct **audit inspections** of all sprinkler heads and escutcheons in the facility. ·This audit will occur weekly for four weeks, bi-weekly for four weeks, and then monthly for a total duration of six months. ·An audit **checklist** has been implemented for Plant staff to verify proper positioning and installation of escutcheons. ·Compliance will be reviewed in the facility's **Quality Assurance and Performance Improvement Meeting**, and any issues will be addressed immediately with additional training or corrective actions. **5. Compliance Date: 3/25/25**	

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K 0712 SS=F Bldg. 01	NFPA 101 Fire Drills Based on record review and interview, the facility failed to conduct quarterly fire drills for 1 of 4 quarters. LSC 19.7.1.6 requires drills to be conducted quarterly on each shift under varied conditions. This deficient practice affects all staff and residents. Findings include: Based on record review of the documentation entitled "Fire Drill" form with the Health Care Administrator on 02/25/25 at 9:32 a.m., there was no documentation for a third shift fire drill being conducted in the second quarter (April, May, and June) of 2024. Based on interview at the time of record review, the Health Care Administrator acknowledged the aforementioned fire drill as not being available for review as of the time of this survey. This item was discussed again with the Health Care Administrator at the exit conference on 02/25/25. 3.1-19(b) 3.1-51(c)	K 0712	**1. What corrective action will be accomplished for those residents found to have been affected by the deficient practice?** No residents were directly affected by this deficiency. However, to ensure staff and resident safety, a **third-shift fire drill** has been scheduled and will be conducted, with documentation to be included in the fire drill records. Additionally the scheduling process for the drills has been revised to ensure compliance with Life Safety standards. **2. How will other residents having the potential to be affected by the same deficient practice be identified, and what corrective action will be taken?** All residents, staff, and visitors in the facility could potentially be affected by fire evacuation procedures. To prevent recurrence: ·A **review of the fire drill scheduling process** has been conducted to ensure that all required drills will be completed on each shift for the current and future quarters. Additionally, a schedule reminder for the required fire drills has been programmed into the community's work order reminder system. **3. What measures will be put**	03/25/2025

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			into place, or what systemic changes will be made to ensure that the deficient practice does not recur? ·The following systemic changes will be implemented to ensure that the alleged deficient practice does not recur: ·A **schedule and reminder system** has been implemented to ensure fire drills are conducted on time for all shifts each quarter (via community's work order tracking/reminder system). ·**Education/in-service training** will be provided to **Health Center Plant staff** highlighting the policy requirements for fire drill scheduling and compliance (see attached policy and in-service) ·The **Health Care Administrator** and **Plant Director** will audit/review fire drill schedules and documentation to ensure that drills are conducted as required (see below for details of audit). **4. How will the corrective action be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?** ·The **Plant Director or designee** will conduct **audit inspections** of all fire drill records to ensure that all shifts have completed the required drills. ·This audit will occur bi-monthly (every two months – prior to end of	

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			each quarter) for a total duration of twelve months. ·An audit **checklist** has been implemented for Plant Director to verify completion of fire drills. ·Compliance will be reviewed in the facility's **Quality Assurance and Performance Improvement Meeting**, and any issues will be addressed immediately with additional training or corrective actions. **5. Compliance Date: 3/25/25**	