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	06/10/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Marquette	8140 Township Line Rd Indianapolis, IN 46260

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure hospital recommendations related to transfers were followed to ensure a resident was free of accidents for 1 of 2 residents reviewed for accidents. (Resident B) This deficient practice resulted in Resident B sustaining an acute distal tibia fracture (a break in the lower end of the tibia, often near the ankle joint). Findings include: During an observation, on 6/10/25 at 10:43 a.m., Resident B was sitting in a wheelchair, her right lower extremity was noted to be in a cast, and she was wearing a brace around her mid-section. A facility reported incident (FRI) indicated, on 5/21/25, the CNA assisted Resident B with ambulating to the toilet. During ambulation, the resident fell toward her right side and her right ankle appeared to roll. Resident B voiced complaints of right ankle pain. The clinical record for Resident B was reviewed on 6/10/25 at 10:20 a.m. The diagnoses included, but were not limited to, wedge compression fracture of third lumbar vertebra, wedge compression fracture of second lumbar vertebra, and wedge compression fracture of T9-T10 vertebra. A preadmission hospital occupational therapist progress note, dated 5/16/25, indicated . Restrictions/Precautions .2 staff assist for safety . The equipment used during therapy was a gait belt and rolling walker. .PLEASE NOTE: If this patient is discharged from acute care prior to the next treatment session, this note will serve as the discharge summary indicating the patient's current functional status A preadmission hospital physical therapist progress note, dated 5/16/25, indicated .Restrictions/Precautions . 2 staff assist for safety .Transfers .Stand Pivot .Moderate Assistance .Transfer Comment .With rolling walker from bed to chair .Gait .Distance 3 ft (feet) .PLEASE NOTE: If this patient is discharged from acute care prior to the next treatment session, this note will serve as the discharge summary indicating the patient's current functional status Resident B was admitted to the facility on [DATE]. A facility document, titled Pre-admission NEEDS ASSESSMENT, dated 5/20/25, indicated the resident was a fall risk and used a wheelchair, a walker, and was full weight bearing. (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0689 Level of Harm - Actual harm Residents Affected - Few	A facility fall-risk assessment, dated 5/20/25, indicated the resident was chair bound. A Basic Interview for Mental Status (BIMS) assessment, dated 5/26/25, indicated Resident B had severe cognitive impairment. A nursing progress note, dated 5/21/25 at 4:59 p.m., indicated the nurse was called to the room and the resident was noted to be lying straight out on her back. The CNA reported Resident B stood with the walker, took a step, and began to fall toward the right. Resident B had her nonskid socks and her TLSO brace (a brace used to limit motion in the thoracic, lumbar, and sacral regions of the spine) on. There was no documentation in Resident B's clinical record to indicate more than one (1) staff member was present to assist Resident B. A typed statement from CNA 2, undated, indicated CNA 2 entered Resident B's room at approximately 2:20 p.m. The resident asked to use the restroom. A walker labeled Therapy was placed in front of Resident B. Resident B stood up, walked to the bathroom, used the bathroom, and washed her hands. On the way back to her recliner, the resident's ankle .folded towards her left ankle . and the resident fell. The CNA called out for help. The nurse responded with another nurse and another CNA. The resident was assessed and the three staff members transferred the resident, using a gait belt, to the bed. An x-ray report of the right ankle, dated 5/21/25, indicated Resident B had sustained an acute distal tibia fracture. During an interview, on 6/10/25 at 11:48 a.m., LPN 2 indicated when she arrived at the room on the day of the incident, Resident B was lying on the floor between her bed and the bathroom. The resident was laying on her back and she was wearing her TLSO brace. Resident B was assisted off the floor by three staff using a gait belt. During an interview, on 6/10/25 at 1:46 p.m., the Therapy Manager indicated Resident B had been evaluated by therapy the same day as the fall. Resident B was a moderate to maximum transfer to the wheelchair due to the resident's cognition. Resident B's gait (manner of walking/moving) was zero feet, and her wheelchair mobility was 10 feet. She indicated prior to the fall Resident B should have been in a wheelchair. During a telephone interview, on 6/10/25 at 1:51 p.m., CNA 2 indicated she had walked into the resident's room about 2:30 p.m., a walker was located beside the bedside table and in reach of the resident. The resident requested to use the bathroom. The CNA indicated she was going to get assistance from another staff member, but Resident B had already stood up. CNA 2 indicated she could not leave the resident and did not want to be direct with the resident. She did not know the resident or how Resident B would react. She assisted the resident to the bathroom. Once Resident B was finished and a couple feet away from her recliner, the resident fell towards her right, onto her right hip. CNA 2 indicated Resident B was using the walker and the CNA did not have a gait belt at that time. There was a walker and a wheelchair in the room. This was her first time assisting Resident B. She indicated the facility did have sheets which told the CNA's how to transfer residents, but there was no documentation related to Resident B on the sheet. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	During an interview, on 6/10/25 at 2:13 p.m., the Director of Nursing (DON) indicated the facility did encourage the use of gait belts. Prior to Resident B's fall and per the hospital, the resident was a moderate to max assist (50-75 percent of the work was completed by the care provider or assistive device). The facility would have initially used the hospital transfer status, received from the hospital in report. CNAs were educated on transfers upon hire and there were gait belts in every resident room. A current facility policy, titled Safe Lifting and Movement of Residents, dated as last revised July 2017 and received from the Director of Nursing on 6/10/25 at 3:19 p.m., indicated .In order to protect the safety and well-being of staff and residents, and to promote quality of care, this facility uses appropriate techniques and devices to lift and move residents .Resident safety, dignity, comfort and medical conditions will be incorporated into goals and decisions regarding the safe lifting and moving of residents A current facility policy, titled ABUSE PREVENTION PROGRAM, dated May 2023 and received from the Director of Nursing on 6/10/25 at 3:18 p.m., indicated .Neglect is defined as failure of the facility, its employees or service providers, to provide goods and services necessary to avoid physical harm, pain, mental anguish or emotional distress 3.1-45(a)(2)