

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(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 CODE 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)
<p>F 0582</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Give residents notice of Medicaid/Medicare coverage and potential liability for services not covered.</p> <p>50901</p> <p>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)</p> <p>Findings include:</p> <p>The NOMNOC and SNF ABN documents for Resident 44 were reviewed on 2/4/25 at 8:50 a.m.</p> <p>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.</p> <p>Resident 44 was provided with the NOMNOC document on 9/9/24, 13 days after the end of service date.</p> <p>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.</p> <p>Resident 44 was provided with the SNF ABN document on 9/9/24, 15 days after the end of service date.</p> <p>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.</p> <p>(continued on next page)</p>

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days 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 disclosable 14 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.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0582</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>A current facility policy, titled Medicare Advance Beneficiary and Medicare 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</p> <p>3.1-4(f)(1)(A)</p> <p>3.1-4(f)(1)(B)</p> <p>3.1-4(f)(2)</p>		

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<p>F 0583</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Keep residents' personal and medical records private and confidential.</p> <p>38872</p> <p>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)</p> <p>Findings include:</p> <p>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 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.</p> <p>At that time, QMA 5 indicated the privacy curtain should have been closed when providing all care.</p> <p>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.</p> <p>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</p> <p>3.1-3(p)(2)</p> <p>3.1-3(p)(4)</p>		

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<p>F 0657</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals.</p> <p>38872</p> <p>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)</p> <p>Findings include:</p> <p>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.</p> <p>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.</p> <p>The last documented care plan meetings were held on 3/14/24 and 6/28/24.</p> <p>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.</p> <p>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.</p> <p>The last documented care plan meeting was held on 5/6/24.</p> <p>During an interview, on 2/3/25 at 9:12 a.m., the Social Services Worker indicated care plan conferences were to be completed quarterly and a note was to be put into the medical record.</p> <p>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.</p> <p>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.</p> <p>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</p> <p>3.1-35(a)</p> <p>3.1-35(d)(2)(B)</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate treatment and care according to orders, resident's preferences and goals.</p> <p>48525</p> <p>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)</p> <p>Findings include:</p> <p>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.</p> <p>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.</p> <p>A review of Resident 34's blood sugars indicated the following results:</p> <p>On 12/18/24, the resident's blood sugar was 69.</p> <p>On 12/28/24, the resident's blood sugar was 65.</p> <p>On 12/28/24, the resident's blood sugar was 425.</p> <p>On 1/5/25, the resident's blood sugar was 51.</p> <p>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.</p> <p>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.</p> <p>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.</p> <p>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</p> <p>3.1-37(a)</p>		

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<p>F 0692</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide enough food/fluids to maintain a resident's health.</p> <p>50901</p> <p>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)</p> <p>Findings include:</p> <p>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.</p> <p>A nutritional note, dated 9/12/24, indicated the Registered Dietitian (RD) recommended to begin weekly weights for closer weight loss monitoring.</p> <p>A progress note, dated 9/12/24, indicated a new order had been placed for weekly weights.</p> <p>A physician's order indicated Resident 8 was to be weighed weekly in the morning, every Monday, for weight loss starting 9/16/24.</p> <p>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.</p> <p>The resident's medical record was missing documentation for the weekly weights in the months of September, November, January, and February.</p> <p>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.</p> <p>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.</p> <p>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.</p> <p>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 continued to be obtained according to the order.</p> <p>(continued on next page)</p>		

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<p>F 0692</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>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.</p> <p>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</p> <p>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</p> <p>3.1-46(a)(1)</p>		

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<p>F 0695</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide safe and appropriate respiratory care for a resident when needed.</p> <p>48525</p> <p>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)</p> <p>Findings include:</p> <p>During an observation, on 1/31/25 at 9:58 a.m., Resident 10's oxygen flow rate was on 2-liters.</p> <p>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.</p> <p>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.</p> <p>The order had 2 different oxygen liter flow rates.</p> <p>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.</p> <p>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.</p> <p>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.</p> <p>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, start the flow of oxygen at the rate per physician order</p> <p>3.1-47(a)(6)</p>		

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<p>F 0810</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide special eating equipment and utensils for residents who need them and appropriate assistance.</p> <p>38872</p> <p>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)</p> <p>Findings include:</p> <p>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.</p> <p>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 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.</p> <p>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.</p> <p>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.</p> <p>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.</p> <p>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.</p> <p>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.</p> <p>A physician's order, initiated on 1/31/25, indicated 2 handle mugs with all meals.</p> <p>During an interview, on 2/4/25 at 1:06 p.m., the Therapy Manager indicated the resident was 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.</p> <p>(continued on next page)</p>		

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<p>F 0810</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>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</p> <p>3.1-21(h)</p>		

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<p>F 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards.</p> <p>38872</p> <p>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)</p> <p>Findings include:</p> <p>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.</p> <p>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.</p> <p>A physician's order, initiated on 1/3/25, indicated 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.</p> <p>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.</p> <p>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.</p> <p>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.</p> <p>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.</p> <p>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.</p> <p>During an interview, on 2/5/25 at 9:19 a.m., the Assistant Director of Nursing indicated the facility determined a need to implement checking the documentation in the Medication and Treatment records due to missing documentation.</p> <p>(continued on next page)</p>		

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<p>F 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>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</p> <p>3.1-50(a)(1)</p> <p>3.1-50(a)(2)</p>		