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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION   | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br>155198  | (X2) MULTIPLE CONSTRUCTION<br>A. Building<br>B. Wing   | (X3) DATE SURVEY COMPLETED<br><br>02/02/2026 |
| NAME OF PROVIDER OR SUPPLIER<br><br>Marquette  |   | STREET ADDRESS, CITY, STATE, ZIP CODE<br><br>8140 Township Line Rd<br>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<br>(Each deficiency must be preceded by full regulatory or LSC identifying information)   |  |  |
| <p>F 0628</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>                     | <p>Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies.</p> <p>Based on interview and record review, the facility failed to provide written notices of discharges to resident representatives or notices to the ombudsman for 3 of 3 residents reviewed for hospitalization and discharge. (Resident 3, 58 and 60) The deficient practice was corrected on 1/16/26, prior to the start of the survey, and therefore was past noncompliance. Findings include: 1. The clinical record for Resident 3 was reviewed on 1/29/26 at 9:32 a.m. The diagnoses included, but were not limited to, pneumonia, atrial flutter, acute respiratory failure with hypoxia, malignant neoplasm of colon, and obstructive and reflux uropathy. A nursing progress note, dated 5/30/25 at 7:37 a.m., indicated the resident was transferred to the emergency room at 6:30 a.m. and the daughter was notified verbally. The note did not indicate the daughter received a written notice at any point after the transfer. During an interview, on 2/2/26 at 3:18 p.m., the Social Services Director indicated the facility went over transfers in the morning meeting and discussed people who were sent out. They brought the form to the meeting and added people to the form daily. The facility realized the family had only been given verbal notices and changed their process. The facility now gives written discharge notifications to resident representatives. They also made sure the Director of Nursing (DON) and Executive Director (ED) receive the ombudsman list which was sent. 2. The clinical record for Resident 58 was reviewed on 2/2/26 at 9:48 a.m. The diagnoses included, but were not limited to, anxiety disorder, major depressive disorder, catatonic disorder due to a known physiological condition, mood affective disorder, type 2 diabetes mellitus, edema, and metabolic encephalopathy. A physician's order, dated 1/5/26, indicated to send the resident to the hospital for a psychiatric evaluation. A nursing progress note, dated 1/5/26 at 2:37 p.m., indicated the resident had a Zoom visit with a psychiatric physician who ordered the resident to be sent to the hospital. The resident was transported by the family. A transfer/discharge report, dated 1/5/26, indicated Resident 58's son was notified of the transfer. It did not indicate a written report, or the bed hold policy was provided to the resident representative. During an interview, on 2/2/26 at 12:02 p.m., the ED indicated Resident 58 was part of the facility's plan of correction implemented prior to the start of this survey. The resident's representative was notified verbally and had received the bed hold policy upon admission; however, the representative had not been given a written transfer/discharge form or another copy of the bed hold when the resident was transferred to the hospital for a psychiatric evaluation on 1/5/26. 3. The clinical record for Resident 60 was reviewed on 2/2/26 at 11:51 a.m. The diagnoses included, but were not limited to, metabolic encephalopathy, contusion of the right thigh, acute and chronic respiratory failure with hypoxia, pulmonary fibrosis, bronchiectasis, acute on chronic diastolic congestive heart failure, anxiety disorder, and moderate dementia with mood disturbance. A progress note, dated 11/24/25 at 1:12 p.m., indicated the resident was discharged at 1:00 p.m. to her assisted living memory care apartment. A social services progress note, dated 11/21/25 at 1:46 p.m., indicated the resident was going to discharge to memory care on 11/24/25 per her request. During an</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.

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| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE                   | (X6) DATE  |
| FORM CMS-2567 (02/99)<br>Previous Versions Obsolete                   | Event ID:<br><br>155198 | Facility ID:<br><br>155198<br><br>If continuation sheet<br>Page 1 of 2 |

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| <p>F 0628</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>                     | <p>interview, on 1/30/26 at 11:15 a.m., the ED indicated the facility had discovered an issue with written transfer and discharge notifications to the resident representatives, bed hold policy, and ombudsman notifications and had completed a plan of correction on 1/13/26. The resident representative had not received a written notice of transfer or the bed hold policy. Audits and staff education was completed on 1/16/26. The ombudsman was not notified of the emergency transfer to the hospital until the oversight was discovered. The plan of correction was completed on 1/16/26. During an interview, on 2/2/26 at 12:04 p.m., the ED indicated the facility had only been notifying the ombudsman of emergent discharges and had not notified the ombudsman of Resident 60's scheduled discharge. This occurrence was already noticed and corrected with the plan of correction the facility had implemented prior to the start of this survey. A current facility policy, titled Transfer Emergency Discharge, undated and provided by the ED on 1/30/26 at 3:26 p.m., indicated .When a resident is temporarily transferred to an acute care facility, a notice of transfer is provided to the resident and resident representative as soon as practicable. The facility notifies the resident, his or her representative, and the representative of the Office of the State LTC Ombudsman in writing of the discharge, including notification the resident has the right to appeal a transfer or discharge. The notice to the representative of the Office of the State LTC Ombudsman is sent at the same time the notice is provided to the resident. The deficient practice was corrected by 1/16/26, after the facility completed house wide audits, the staff were educated, and the policy was updated. 3.1-12(a)(6)(A)(ii) 3.1-12(a)(6)(A)(iv)</p> |  |  |