STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155855	A. BUILDING 00 B. WING	09/22/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
MCGIVNEY HEALTH CARE CENTER	2907 EAST SMOKY ROW CARMEL, IN 46033

(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
F 0000 Bldg. 00	This visit was for a Recertification and State Licensure Survey. Survey dates: September 17, 18, 19, 20, 21 and 22, 2023 Facility number: 000545 Provider number: 155855 AIM number: 100267350 Census Bed Type: SNF/NF: 35 Total: 35 Census Payor Type: Medicaid: 34 Other: 1 Total: 35 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review was completed on September 29, 2023.	F 0000		
F 0580 SS=D Bldg. 00	483.10(g)(14)(i)-(iv)(15) Notify of Changes (Injury/Decline/Room, etc.) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's			

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

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	physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). §483.10(g)(15) Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9).			

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	Based on interview and record review, the facility failed to notify the physician of a weekly weight gain and a blood sugar outside the call parameters for 2 of 2 residents reviewed for notification of change. (Resident 1 and 12) Findings include: 1. The record for Resident 1 was reviewed on 9/21/23 at 11:34 a.m. Diagnoses included, but were not limited to, type 2 diabetes myelitis, dementia, and hypertension. A care plan, revised 2/9/17, indicated the resident was on a diuretic (furosemide) due to hypertension. The interventions included, but were not limited to, weekly weight and notify the physician per protocol. A physician's order, dated 10/1/20, indicated to weigh the resident weekly and if there was a greater than 3-pound weight gain notify the physician. A facility vital sign documentation indicated the following weights: a. The weight, on 8/25/22, was 209 pounds (lbs.). b. The weight, on 9/1/22, was 216 lbs. The resident had a 7 lb. weight gain in one week. There was no documentation to indicate the physician was notified of the 7-pound weight gain. During an interview, on 9/22/23 at 10:32 a.m., the Director of Nursing (DON) indicated if there was an order to notify the physician of a weight gain then the physician needed to be called.	F 0580	MHCC Plan of Correction 2023 F-580- Failure to Notify 1. The facility failed to notify the MD about Resident #12's low blood sugar and Resident #1 weight gain. 2. All residents have the potential to be affected by this deficient practice. 3. An In-service will be completed November 6 on proper Accucheck reading and protocols to notify the physician. 4. Audit will be done for weight loss for the next three months with 100% accuracy and presented to QAPI. Daily audits for 30 days for Accucheck accuracy and protocol.	11/06/2023

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	During an interview, on 9/22/23 at 11:45 a.m., the Executive Director (ED) indicated there was no documentation to show the physician was notified of the weight gain for Resident 1. 2. The record for Resident 12 was reviewed on 9/19/23 at 12:29 p.m. Diagnoses included, but were not limited to, type 2 diabetes mellitus, paranoid schizophrenia, dysphagia (difficulty swallowing), depressive disorder, and blindness in the right eye. A physician's order, dated 10/21/16, indicated to give Humalog (insulin for blood glucose levels) solution 100 unit/ml(milliliter). Inject the insulin as per sliding scale if the blood glucose levels were as follows: a. 0 - 149 = 0 units b. 150 - 200 = 2 units c. 201 - 250 = 4 units d. 251 - 300 = 6 units e. 301 - 350 = 8 units f. 351 - 400 = 10 units. Call the physician if the blood glucose levels were below 60 or over 400. The resident's blood glucose level document indicated the level, on 4/25/2023 at 10:39 p.m., was 433 and on 6/22/23 at 11:18 p.m., was 495. There was no documentation of the physician being notified for the blood glucose levels of 495 and 433. During an interview, on 9/20/23 at 10:00 a.m., the ED indicated they did not have documentation for the physician being notified of the blood glucose levels over 400. The physician needed to be called since the information was requested. During an interview, on 09/20/23 at 3:00 p.m., the			

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	DON indicated the blood glucose level, on 6/22/23 at 11:18 a.m., was 496 and was taken by the Qualified Medical Assistant (QMA). The blood glucose level was crossed out on the Medication Administration Record (MAR) and the physician was not notified of the blood glucose level greater than 400. She would not call the physician if she got a high number on the Accu-check machine. She would take another blood glucose level. The facility did not have a notification of physician policy at the exit conference. A current policy, titled "Blood Glucose Monitoring," revised May 16, 2019 and received from the ED on 11/8/21 at 4:53 p.m., indicated "...The standard of practice is for all nursing personnel to have direction and guidance through which services are expected to the changing nature of health care provision for people with diabetes...Nursing personnel are subject to Routine Procedures and Non-Routine procedures during the course of action to monitor blood glucose...Document blood glucose results on Blood Sugar Log and notify physician of any readings outside of directed parameters specified by physician caring for management of diabetes...." 3.1-5(a)(3)			
F 0609 SS=D Bldg. 00	483.12(b)(5)(i)(A)(B)(c)(1)(4) Reporting of Alleged Violations §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including			

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	injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. Based on interview and record review, the facility failed to ensure a significant medication error which resulted in a resident requiring an intensive care stay of 5 days in the hospital was reported to the State Agency for 1 of 1 resident reviewed for reporting. (Resident 20) Finding includes: The record for Resident 20 was reviewed on 09/19/23 at 2:01 p.m. Diagnoses included, but were not limited to, dementia with other behavioral disturbance, bradycardia, abnormal weight loss, mood disorder, chronic pain syndrome, and hypertension.	F 0609	MHCC Plan of Correction 2023 F-609- Failure to Notify 1 The facility failed to ensure a significant medication error which resulted in a resident requiring an intensive care stay of 5 days in the hospital was reported to the State Agency. 2 All residents have the potential to be affected by this deficient practice. 3 Executive Director will report significant medication error. 4 CEO will audit ED for 3 months with 100% accuracy.	10/27/2023

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	A progress note, dated 6/30/23 at 9:25 am, indicated the resident was noted to be lethargic. The skin was cool to touch, he had increased slurring speech, and his speech was garbled. The provider was notified and requested a transfer to the emergency department. An SBAR (situation, background, assessment, and recommendation form), dated 6/30/23 at 9:36 a.m., indicated the resident had a change in mental status and was given another resident's medications. A hospital patient summary report, dated 6/30/23 at 2:46 pm, indicated the admitting diagnosis was an overdose of antipsychotic accidental or unintentional accidental overdose of beta-adrenergic blocker. The resident was diagnosed with acute toxic encephalopathy (brain disfunction caused by toxic exposure) due to receiving the medications for another resident. Poison control recommended flumazenil (to help the resident wake up after an overdose) which was given in the emergency department. The resident also had a diagnosis of lactic acidosis (too little oxygen reaches body tissues) likely related to medications and poor intake. A diagnosis of sinus bradycardia (low heart rate) resulted from an inadvertent dose of metoprolol tartrate (for high blood pressure and heart rate)100mg. A progress note, from the attending physician in medical intensive care unit, dated 6/30/23 at 12:27 p.m., indicated the resident presented from his living facility sedated (sleepy). The resident was given medications which were not his own. A progress note, dated 7/5/23 at 2:09 p.m., indicated the resident returned to the facility via			

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	stretcher, provider notified of medication changes at this time, Director of nursing was notified of the return. A medication variance report, dated 6/30/23 at 9:00 a.m., indicated the type of variance was the wrong resident and the reason was failure to identify the resident. Nurse 18 was placed back in orientation. A termination notice, dated 9/2/23, indicated on 6/30/23 a medication error resulted in the hospitalization of a resident. Nurse 18 continued to make errors with medication administration and her employment with the facility was terminated. During an interview, on 09/21/23 at 10:13 a.m., the Executive Director indicated he was aware of the significant medication error and the employee was terminated. There was no policy for reporting incidents to the Indiana Department of Health. 3.1-28(c)			
F 0641 SS=D Bldg. 00	483.20(g) Accuracy of Assessments §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. Based on interview and record review, the facility failed to ensure a new diagnosis of systolic heart failure was included in the MDS (Minimum Data Set) under medical diagnoses for 1 of 1 resident reviewed for assessments. (Resident 32) Finding includes: The record for Resident 32 was reviewed on 9/19/23 at 11:31 a.m. Diagnoses included, but were	F 0641	MHCC Plan of Correction 2023 F-641 1 The facility failed to ensure a new diagnosis of systolic heart failure was included in the MDS (Minimum Data Set) under medical diagnoses for 1 of 1 resident reviewed for assessments. 2 All residents have the	10/27/2023

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	not limited to, dementia, depressive episode, psychotic disorder with delusions due to known physiological condition, restlessness and agitation, pain in the right leg, and delusional disorders. A progress note, dated 4/4/23 at 12:09 p.m., indicated the resident had swollen arms, pitting edema to both ankles and abdomen. She had diminished lung sounds noted throughout the lobes. The provider was notified, and a new order was received to send the resident to the emergency department for evaluation and treatment. A hospital discharge summary note, dated 4/9/23 at 1:25 p.m., indicated a new diagnosis of acute systolic heart failure exacerbation. The echocardiogram indicated an ejection fraction (percentage of blood pumped out with the heartbeat) of 25 to 30% with unknown etiology at this time. The provider indicated the uncontrolled atrial flutter could have caused the onset of heart failure. A progress note, dated 4/10/23 at 10:18 a.m., indicated the resident's weight was 118 pounds upon return from hospitalization and was 150 pounds prior to hospitalization. The resident was overloaded per emergency department nurse. A progress note, dated 4/10/23 at 2:46 p.m., indicated the Registered Dietitian was aware of the weight gain due to an increase in edema. The resident had been discharged to an acute setting due to swelling and had returned today. She will continue to monitor. A quarterly MDS assessment, dated 6/20/23, indicated there was no diagnosis of systolic		potential to be affected by this deficient practice. 3 Diagnosis checked within 72 hours by IDT team. Review med upon return from hospital in clinical meetings. Ensure all diagnosis are entered into the charts. In-service staff on admissions with new orders. 4 Audit will be done in clinical meetings for 3 months for 100% accuracy.	

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	congestive heart failure in the section for active diagnoses. An annual MDS assessment, dated 8/24/23, indicated there was no diagnosis of systolic heart failure entered into the section for active medical diagnoses. During an interview, on 9/22/23 at 11:17 a.m., the MDS Coordinator indicated she was not informed of the information with the resident's new diagnosis of heart failure, and it was not put on the quarterly or annual assessment. During an interview, on 9/22/23 at 11:20 a.m., the MDS Coordinator indicated there was no policy for MDS. The RAI (Resident Assessment Instrument) manual was followed. A current publication, titled "Long - Term Care Facility Resident Assessment Instrument 3.0 User's Manual," dated 10/2019, indicated "...disease processes can have a significant adverse effect on an individual's health status and quality of life...this section identifies active diseases and infections that drive the current plan of care...the disease conditions in this section require a physician-documented diagnosis in the last 60 days...." 3.1-31(d)(3) 3.1-31(e)			
F 0644 SS=D Bldg. 00	483.20(e)(1)(2) Coordination of PASARR and Assessments §483.20(e) Coordination. A facility must coordinate assessments with the pre-admission screening and resident review (PASARR) program under Medicaid in subpart C of this part to the maximum extent			

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	practicable to avoid duplicative testing and effort. Coordination includes: §483.20(e)(1)Incorporating the recommendations from the PASARR level II determination and the PASARR evaluation report into a resident's assessment, care planning, and transitions of care. §483.20(e)(2) Referring all level II residents and all residents with newly evident or possible serious mental disorder, intellectual disability, or a related condition for level II resident review upon a significant change in status assessment. Based on interview and record review, the facility failed to ensure another PASARR (Preadmission Screening and Resident Review) level I was completed when the resident was prescribed an antipsychotic medication for 1 of 2 residents reviewed for PASARR. (Resident 29) Finding includes: The record for Resident 29 was reviewed on 9/20/23 at 4:30 p.m. Diagnoses included, but were not limited to, unspecified dementia, mood disturbance, anxiety disorder, and psychotic disorder with delusion. A PASARR level I, dated 9/4/20, indicated the resident had no mental health medication and no level II was required due to situational symptoms. The level I screen indicated a PASARR disability was not present because of the following reason: Low level behavioral health symptoms were present. However, those appear to be situational. If the individual's symptoms or behaviors did not improve or resolve within 30-60 days of this screen, then the nursing facility must submit an	F 0644	MHCC Plan of Correction 2023 F-644 1 The facility failed to ensure another PASARR (Preadmission Screening and Resident Review) level I was completed when the resident was prescribed an antipsychotic medication for 1 of 2 residents reviewed for PASARR. 2 All residents have the potential to be affected by this deficient practice. 3 Resident Audit who has had a change of new antipsychotic medication or new psychotic diagnosis is added. 4 Audit will be done in clinical meetings for 3 months for 100% accuracy.	10/27/2023

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	updated status change level I screen to reevaluate the need for a PASARR level II behavioral health evaluation. A physician's order, dated 5/18/23, indicated Zyprexa (an antipsychotic medication) 2.5 mg (milligram) at bedtime related to psychotic disorder with delusions due to known physiological condition. During an interview, on 9/21/23 at 3:25 p.m., the Social Services Director indicated she did not know she was supposed to do another PASARR level I when the resident was started on an antipsychotic medication, or a new psychotic diagnosis was added. The facility did not have a PASARR policy. 3.1-16(d)(1)(A) 3.1-16(d)(1)(B)			
F 0656 SS=D Bldg. 00	483.21(b)(1)(3) Develop/Implement Comprehensive Care Plan §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under			

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	§483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. §483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (iii) Be culturally-competent and trauma-informed.			
	Based on record review and interview, the facility failed to ensure a resident with a new seizure diagnosis had a care plan for 1 of 1 resident reviewed for care plans. (Resident 22) Finding includes: The record for Resident 22 was reviewed on	F 0656	**MHCC Plan of Correction 2023 F-656** **1 The facility failed to ensure a resident with a new seizure diagnosis had a care plan for 1 of 1 resident reviewed for care plans.**	10/27/2023

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(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
	9/19/23 at 12:19 p.m. Diagnoses included, but were not limited to, unspecified intracranial injury with loss of consciousness of unspecified duration, nontraumatic subarachnoid hemorrhage, epileptic seizures, and fracture of nasal bone. A physician's order, dated 7/14/23, indicated lacosamide (a seizure medication) 150 mg (milligrams) twice daily for seizures. A progress note, dated 7/14/23 at 12:12 a.m., indicated the resident was walking down the hall going to the shower. He was noted hitting the wall and banister while starting to seize. He had issues breathing and a seizure with full tonic-clonic movement. The seizure activity lasted 3 minutes. A hospital discharge note, dated 7/17/23, indicated the resident had a 3-minute grandmal seizure witnessed at the extended care facility. Facility staff indicated the resident had no previous seizures. He was to be discharged to the extended care facility with standard seizure precautions and medications. During an interview, on 9/21/23 at 1:35 p.m., the Director of Nursing indicated the resident did not have a care plan for seizures. There was no care plan for seizure precautions. There was no policy for seizure precautions or care plans. 3.1-35(a) 3.1-35(b)(1)		**2 All residents have the potential to be affected by this deficient practice.** **3 Diagnosis checked within 72 hours by IDT team. Review med upon return from hospital in clinical meetings. Ensure all diagnosis are entered into the charts. In-service staff on admissions with new orders.** **4 Audit will be done in clinical meetings for 3 months for 100% accuracy.**	
F 0689 SS=D Bldg. 00	483.25(d)(1)(2) Free of Accident Hazards/Supervision/Devices			

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	155855	A. BUILDING 00 B. WING	09/22/2023

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	§483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. Based on interview and record review, the facility failed to document and investigate a fall with a major injury for 1 of 4 residents reviewed for falls. (Resident 186) Finding includes: The record for Resident 186 was reviewed on 9/20/23 at 1:37 p.m. Diagnoses included, but were not limited to, Alzheimer's disease with late onset, non-traumatic chronic subdural hemorrhage, generalized anxiety disorder, and cognitive communication deficit. A progress note, dated 7/22/23 at 3:13 p.m., indicated the resident was experiencing episodes of increased confusion, stumbling during ambulation, and did not feed himself during mealtimes. The resident was sent to the hospital. A hospital presenting symptoms details report, dated 7/22/23, indicated the resident had increased confusion. The resident was not eating on his own at the long-term care (LTC) facility as he usually did and had an unwitnessed fall. The emergency department work up showed the resident had an acute on chronic subdural hematoma (usually caused by a head injury which caused blood to pool between the brain and its outermost covering) with a 5-millimeter (mm) thickness. The resident's other diagnosis	F 0689	**MHCC Plan of Correction 2023** **F-6891 The facility failed to document and investigate a fall with a major injury for 1 of 4 residents reviewed for falls.2 All residents have the potential to be affected by this deficient practice.3 Fall risk assessments on all residents by November 6. Resident 186 fall care plan updated.4 Audit will be done in clinical meetings for 3 months for 100% accuracy.**	10/27/2023

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	included, but were not limited to, sepsis secondary to urinary tract infection (UTI) and right chest wall cellulitis, complicated UTI from e. coli (a bacteria normally found in the intestines), an unwitnessed fall, and acute on chronic subdural hematoma. A hospital geriatric consult, dated 7/24/23 at 3:01 p.m., indicated the resident was well known to their services and had a history of Alzheimer's dementia who presented to the Emergency Room, on 7/22/23, after an unwitnessed fall. The staff at the LTC facility noted the resident was more confused than normal and unsteady on his feet. The resident was not eating on his own and the facility thought it was due to generalized weakness. When the staff at the facility could not find the resident after lunch, they went looking for the resident. The resident was located in the bathroom near the dining room and was oriented to self only. The facility activated emergency medical services and the resident was transported to the emergency room. A facility fall risk evaluation, dated 8/3/23 at 6:55 p.m., indicated the resident had a history of falls and had 1-2 falls in the past 3 months. The resident's fall risk score was 18 which indicated the resident was at a risk for falls. The care plans did not include the resident was at a risk for falls. During an interview, on 9/21/23 at 11:53 a.m., the Executive Director (ED) indicated the Unit Manager would be responsible for reviewing the hospital discharge records. He was not aware the resident had fallen prior to the hospital admission on 7/22/23 and the facility did not have a fall report or an incident report.			

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	The Nursing Fall Procedure Check List included but was not limited to, complete vital signs, complete a physical assessment, document a fall progress note, create a fall intervention, complete a fall risk evaluation, complete a situation, background, assessment and recommendations (SBAR) assessment. A current policy, titled "Fall Assessment Policy," effective 2011, revised 2020 and received from the ED on 9/21/23 at 11:30 a.m., indicated "...has developed a Fall Assessment policy designed to assist licensed personnel in fall follow up procedures...A Fall Risk Assessment shall be completed upon admission and recommendation made for immediate interventions accordingly. Those interventions will be addressed on the CNA [certified nursing assistant] Assignment Sheet...and the resident's care plan...Should a resident incur a fall; the licensed personnel will follow the Fall Procedure Check List. Immediate interventions shall be initiated and communicated to direct caregivers as warranted. The Post Fall Investigation shall be forwarded to the Director of Nursing [DON] for IDT [interdisciplinary team] Review. 3.1-45(a)(1)			
F 0690 SS=D Bldg. 00	483.25(e)(1)-(3) Bowel/Bladder Incontinence, Catheter, UTI §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain.			

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	§483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. §483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible.			
	Based on observation, interview and record review, the facility failed to ensure a resident being treated for a urinary tract infection was provided timely incontenent care and was free from wearing two incontinent briefs, failed to obtain a culture and sensitivity after a urinalysis, and failed to prevent a recurrent urinary tract infection for 2 of 3 residents reviewed for urinary tract infections. (Resident 6 and 32) Findings include: 1. During an interview, on 9/22/23 at 2:20 p.m.,	F 0690	MHCC Plan of Correction 2023 F-690 1. The facility failed to ensure a resident being treated for a urinary tract infection was provided timely incontinent care and was free from wearing two incontinent briefs, failed to obtain a culture and sensitivity after a urinalysis, and failed to prevent a recurrent urinary tract infection for 2 of 3 residents reviewed for urinary tract	11/06/2023

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	Resident 6 indicated she had been waiting two hours to have her wet brief changed and her buttock was hurting. The resident asked the Certified Nursing Assistant (CNA) 13 at noon to be changed and was still waiting. During an observation, on 9/22/23 at 2:31 p.m., Qualified Medication Assistant (QMA) 11 and CNA 12 entered the resident's room to provide peri-care. QMA 11 indicated Resident 6 had a strong urine odor. QMA 11 opened the left side of the incontinent brief and tucked the end of the incontinence brief under the resident's left side. The resident was wearing two briefs. The staff turned the resident over to remove the mechanical lift pad (a pad used with a device to assist with transfers for individuals who require support). The pad, the resident's dress, and the brief were all wet with urine. The brief was extremely wet with bowel movement (BM) smears in the brief. The record for Resident 6 was reviewed on 9/20/23 at 2:19 p.m. Diagnoses included, but were not limited to, hemiplegia (paralysis) affecting the right dominant side, depressive disorder, type 2 diabetic mellitus, and anxiety disorder. The MDS (Minimum Data Set) assessment, dated 8/7/23, indicated the resident needed extensive assistance with toilet use. A care plan, dated 1/11/23, indicated the resident had bladder incontinence related to physical limitations. The interventions included, but were not limited to, the resident used disposable briefs, to change every two hours and when needed, and clean the peri-area with each incontinence episode. A care plan, dated 1/11/23, indicated the resident		infections. (Resident 6 and 32) 2. All residents have the potential to be affected by this deficient practice. 3. In-service hand washing and proper technique of perineal care on November 6. Retest UTI residents after completion of antibiotic series. 4. Honor Resident wishes in Care Plan with double briefing. Adding Cranberry juice with all residents for breakfast. Audit of UTI residents for 3 months for 100% in clinical meeting. Add retesting to policy. **="" span="">**	

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	needed assistance with activities of daily living. The interventions included, but were not limited to, the resident was a total dependence with up to 2 staff for toilet use. An Emergency Room (ER) hospital record, dated 9/2/23, indicated the resident was admitted with a diagnosis of an UTI (urinary tract infection). A physician's order, dated 9/5/23, indicated to give Pyridium (analgesic for urinary tract infection) 200 mg (milligrams) tablet every 8 hours as needed for dysuria (painful urination) for 30 days. A physician's order, initiated on 9/5/23, indicated to give Ceftriaxone sodium (an antibiotic) 1 gram intravenously at bedtime related to urinary tract infection for 13 days. During an interview, on 9/22/23 at 2:20 p.m., QMA 11 indicated she was not sure when the resident was last changed and why the resident was wearing two briefs. The resident's dress, mechanical lift pad and the two briefs were wet and had smears of bowel movement. The resident also had an open area along her right buttock and the facility did not double brief residents. During an interview, on 9/22/23 at 3:33 p.m., CNA 13 indicated she got the resident up at 8:00 am. The resident refused care at 8:00 a.m., and at 12:00 p.m. When asked when she was last changed, CNA 13 indicated she changed her at 8:00 a.m., and she did not know the resident had two briefs on. During an interview, on 9/22/23 at 3:40 p.m., the Director of Nursing (DON) indicated double briefing was a personal preference.			

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	During an interview, on 9/22/23 at 3:40 p.m., the Executive Director (ED) indicated they did not have a policy on activities of daily living (ADL) care or double briefing a resident. 2. The record for Resident 32 was reviewed on 9/19/23 at 11:31 a.m. Diagnoses included, but were not limited to, dementia, depressive episode, psychotic disorder with delusions due to known physiological condition, restlessness and agitation, UTI, and delusional disorders. A progress note, dated 6/28/23 at 11:00 a.m., indicated the resident complained of not feeling well. She indicated she had hit her head and she needed to go to the hospital. A hard area was noted at the side of the temple. Her vital signs were a blood pressure of 128/63, pulse 93 and respirations 20. Increased confusion was noted and a cracked tooth. A hospital noted, dated 6/28/23, indicated a urinalysis was obtained. The results were positive for nitrites, small amount of leukocyte esterase, slightly cloudy, 6-10 white blood cells, and marked bacteria. There was no urine culture and sensitivity from the urinalysis. A progress note, dated 6/28/23 at 6:44 p.m., indicated the resident returned from the hospital. The orders from the emergency department were cephalexin 500 mg (milligrams) twice daily for 14 days. A physician's order, dated 6/29/23, indicated cephalexin 500 mg twice daily.			

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	A urinalysis report, dated 8/10/23 at 4:15 p.m., indicated the urine color was amber, cloudy, had 3 + leukocytes, 6-30 red blood cells, 50 white blood cells, many bacteria, calcium oxalate crystal and mucus. A urine culture report, date 8/12/23 at 4:05 p.m., indicated the bacteria was Escherichia Coli 70, 000 to 99, 000 CFU (viable cells)/ml and ceftriaxone was the most effective antibiotic. A physician's order, dated 8/14/23, indicated ceftriaxone 1 gm (gram) injection. There was no policy regarding urinary tract infections or antibiotic surveillance provided prior to exit. 3.1-41(a)(2)			
F 0725 SS=D Bldg. 00	483.35(a)(1)(2) Sufficient Nursing Staff §483.35(a) Sufficient Staff. The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e). §483.35(a)(1) The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents			

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	in accordance with resident care plans: (i) Except when waived under paragraph (e) of this section, licensed nurses; and (ii) Other nursing personnel, including but not limited to nurse aides. §483.35(a)(2) Except when waived under paragraph (e) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty. Based on observation, record review and interview, the facility failed to ensure there was 24 hours of CNA (Certified Nursing Assistant) coverage during the day and evening shift according to the facility assessment, failed to ensure staff were able to complete documentation on the Medication Administration Record (MAR), and failed to ensure a resident was provided timely incontinent care for 8 shifts and 2 of 2 residents reviewed for sufficient staffing. (5/28/23 day shift, 5/27/23 evening shift, 5/21/23 evening shift, 5/7/23 evening shift, 5/6/23 day and evening shift, and 4/30/23 day and evening shift, and Residents 28 and 6) Finding includes: 1. A payroll Based Journal (PBJ) report, for the third quarter of 2023, indicated the facility triggered for low weekend staffing. During an interview, on 9/19/23 at 2:53 p.m., the Executive Director (ED) indicated the facility assessment showed the need for 24 hours Certified Nursing Assistant (CNA) coverage during the day and evening shifts. This would be a total of 3 CNAs for the day and evening shifts. If the facility was using agency CNAs, then he would only staff the facility with 2 CNAs for the day and evening shifts since it was a budget issue	F 0725	**MHCC Plan of Correction 2023 F-725** **1 the facility failed to ensure there was 24 hours of CNA (Certified Nursing Assistant) coverage during the day and evening shift according to the facility assessment, failed to ensure staff were able to complete documentation on the Medication Administration Record (MAR)** **2 All residents have the potential to be affected by this deficient practice.** **3 In-service nursing staff on Medication Administration Record. ED corrected facility assessment to weekend levels for all days.** **4 Unit Manager will audit MAR for 3 months with 100% accuracy.**	10/27/2023

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	even though the facility assessment showed the need for 3 CNAs. If the facility was using their own staff, then 3 CNAs would be scheduled. 2. The record for Resident 28 was reviewed on 9/19/23 and 3:39 p.m. Diagnoses included, but were not limited to, dementia without behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety disorder. A MAR, dated for the month of July 2023, indicated the following medications were not signed as administered or not administered: a. Buspirone HCl (anxiolytic) 15mg one tablet three times a day on 7/17/23 at 9:00 p.m., and 7/23/23 at 2:00 p.m. b. Depakote DR (delayed release) 125 mg one tablet three times a day on 7/17/23 at 9:00 p.m., and 7/23/23 at 2:00 p.m. d. Sodium chloride 1 gram give one tablet three times a day on 7/17 and 7/23/23 at 9:00 p.m. A MAR, dated for the month of August 2023, indicated the following medications were not signed as administered or not administered: a. Atenolol (high blood pressure) 25 mg one tablet daily on 8/25 and 8/31/23 at 9:00 a.m. b. Colace (stool softener) 100 mg one tablet daily on 8/25 and 8/31/23 at 9:00 a.m. c. Vitamin B (dietary supplement) one tablet twice a day on 8/25 and 8/31/23 at 9:00 a.m. d. Buspirone HCl (anxiolytic) 10 mg one tablet twice a day 8/24/23 at 9:00 p.m., 8/25 and 8/31/23 at 9:00 a.m. e. Depakote (anticonvulsant) 5 mg one tablet daily on 8/24/23 at 9:00 p.m. f. Sodium chloride 1 gram one tablet three times a day on 8/2/423 at 9:00 p.m. g. Tamsulosin (urinary retention) 0.4 mg one tablet daily on 8/25/23 at 9:00 p.m.			

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A care plan, revised 12/7/22, indicated the resident had impaired cognitive function and impaired thought processes related to dementia diagnoses. The interventions included, but were not limited to, administer medication as ordered.

3a. The record for Resident 6 was reviewed on 9/20/23 at 2:19 p.m. Diagnoses included, but were not limited to, chronic obstructive pulmonary disorder, depressive disorder, type 2 diabetes mellitus, and anxiety disorder.

A MAR, dated for the month of August 2023, indicated the following medications were not signed as administered or not administered:
a. Aspirin (Nonsteroidal anti-inflammatory and blood thinner) 81 mg (milligram) one tablet daily on 8/25 and 8/31/23 at 9:00 a.m.
b. Cyclobenzaprine (muscle relaxant) HCI 10 mg one tablet daily on 8/25 and 8/31/23 at 9:00 a.m.
c. Doxepin (antidepressant) HCI 10 mg one tablet daily on 8/24/23 at 9:00 a.m.
d. Famotidine (antacid) 40 mg one tablet daily on 8/25 and 8/31/23 at 9:00 a.m.
e. Fluticansone-Umeclidin-Vilant (steroid) inhalation Aerosol 100-62.5-25 mcg/act one inhale daily at 8/25 and 8/31/23 at 9:00 a.m.
f. Lasix (diuretic) 20 mg one tablet daily on 8/25 and 8/31/23 at 9:00 a.m.
g. Metformin (anti-diabetic med) for blood HCI 500 one tablet daily on 8/25 and 8/31/23 at 9:00 a.m.
h. Montelukast Sodium (anti-inflammatory) 10 one tablet on 8/24/23 at 9:00 p.m.
i. Venlafaxine HCI (anti-depressant) 75 mg one tablet daily on 8/25 and 8/31/23 at 9:00 a.m.
j. Buspirone (anxiolytic) HCI 10 mg one tablet twice a day on 8/25 and 8/31/23 at 9:00 a.m.
k. Depakote Sprinkles Delayed Sprinkle (anticonvulsant) one tablet twice a day on 8/25

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	and 8/31/23 at 9:00 a.m. l. Norco (pain) 5-325mg one tablet twice a day on 8/25 and 8/31/23 at 9:00 a.m. m. Acetaminophen (pain) 325 mg two tablets three times a day on 8/19/23 at 2:00 p.m., 8/25 and 8/31/23 at 9:00 a.m. and 2:00 p.m. n. Gabapentin (nerve pain) 600 mg one tablets three times a day on 8/19 and 8/24/23 at 9:00 p.m., 8/25 and 8/31/23 at 9:00 a.m. and 2:00 p.m. b. During an interview, on 9/22/23 at 2:20 p.m., Resident 6 indicated she had been waiting two hours to have her wet brief changed and her buttock was hurting. The resident asked the Certified Nursing Assistant (CNA) 13 at noon to be changed and was still waiting. During an observation, on 9/22/23 at 2:31 p.m., Qualified Medication Assistant (QMA) 11 and CNA 12 entered the resident's room to provide peri-care. QMA 11 indicated Resident 6 had a strong urine odor. QMA 11 opened the left side of the incontinent brief and tucked the end of the incontinence brief under the resident's left side. The resident was wearing two briefs. The staff turned the resident over to remove the mechanical lift pad (a pad used with a device to assist with transfers for individuals who require support). The pad, the resident's dress, and the brief were all wet with urine. The brief was extremely wet with bowel movement (BM) smears in the brief. The record for Resident 6 was reviewed on 9/20/23 at 2:19 p.m. Diagnoses included, but were not limited to, hemiplegia (paralysis) affecting the right dominant side, depressive disorder, type 2 diabetic mellitus, and anxiety disorder. The MDS (Minimum Data Set) assessment, dated 8/7/23, indicated the resident needed extensive			

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	155855	A. BUILDING 00 B. WING	09/22/2023

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	assistance with toilet use. A care plan, dated 1/11/23, indicated the resident had bladder incontinence related to physical limitations. The interventions included, but were not limited to, the resident used disposable briefs, to change every two hours and when needed, and clean the peri-area with each incontinence episode. A care plan, dated 1/11/23, indicated the resident needed assistance with activities of daily living. The interventions included, but were not limited to, the resident was a total dependence with up to 2 staff for toilet use. During an interview, on 9/22/23 at 2:20 p.m., QMA 11 indicated she was not sure when the resident was last changed and why the resident was wearing two briefs. The resident's dress, mechanical lift pad and the two briefs were wet and had smears of bowel movement. The resident also had an open area along her right buttock and the facility did not double brief residents. During an interview, on 9/22/23 at 3:33 p.m., CNA 13 indicated she got the resident up at 8:00 am. The resident refused care at 8:00 a.m., and at 12:00 p.m. When asked when she was last changed, CNA 13 indicated she changed her at 8:00 a.m., and she did not know the resident had two briefs on. During an interview, on 9/22/23 at 3:40 p.m., the Executive Director (ED) indicated they did not have a policy on activities of daily living (ADL) care or double briefing a resident. During an interview, on 9/22/23 at 10:32 a.m., the Director of Nursing (DON) indicated the MAR			

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	should not have blank spaces and she could call the agency staff and ask if they gave the medication. She really doubted they would remember from back in July and August. They should always sign off the medications on the MAR. During an interview, on 9/21/23 at 2:33 p.m., the ED indicated he did not have a staffing policy. 3.1-17(a)			
F 0727 SS=D Bldg. 00	483.35(b)(1)-(3) RN 8 Hrs/7 days/Wk, Full Time DON §483.35(b) Registered nurse §483.35(b)(1) Except when waived under paragraph (e) or (f) of this section, the facility must use the services of a registered nurse for at least 8 consecutive hours a day, 7 days a week. §483.35(b)(2) Except when waived under paragraph (e) or (f) of this section, the facility must designate a registered nurse to serve as the director of nursing on a full time basis. §483.35(b)(3) The director of nursing may serve as a charge nurse only when the facility has an average daily occupancy of 60 or fewer residents. Based on interview and record review, the facility failed to ensure a Registered Nurse (RN) was in the facility for 8 hours each day during a 24-hour period for 27 days of the third quarter reviewed for sufficient staffing. (April 1, 2, 7, 8, 9, 15, 16, 22, 29, and 30, May 6, 7, 13, 14, 20, 21, 27, 28, and 29, June 3, 4, 10, 11, 17, 18, 24 and 25, 2023). Finding includes:	F 0727	**MHCC Plan of Correction 2023 F-7271 the facility failed to ensure a Registered Nurse (RN) was in the facility for 8 hours each day during a 24-hour period for 27 days of the third quarter reviewed for sufficient staffing.2 All residents have the potential to be affected by this deficient**	10/27/2023

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
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	A Payroll Based Journal (PBJ) report, for the third quarter of 2023, indicated the facility did not have RN coverage for April 1, April 2, April 7, April 8, April 9, April 15, April 16, April 22, April 29, April 30, May 6, May 7, May 13, May 14, May 20, May 21, May 27, May 28, May 29, June 3, June 4, June 10, June 11, June 17, June 18, June 24 and June 25, 2023. The facility assessment, received at entrance and updated on 6/6/2023, indicated the facility was to have 8 hours of RN coverage each day. During an interview, on 9/19/23 at 11:03 a.m., the Director of Nursing (DON) indicated she started working as the DON at the end of February. She was the only RN who worked at the facility. She was at the facility 4 days per week and usually took either Monday or Friday off along with the weekends. During an interview, on 9/19/23 at 2:53 p.m., the ED indicated the facility assessment showed there was a need for RN coverage 8 hours each day. The DON was the only RN who worked at the facility. The facility did not have RN coverage for the dates listed on the PBJ report. During an interview, on 9/22/23 at 2:33 p.m., the ED indicated the facility did not have a staffing policy. 3.1-17(b)(3)		**practice.3 McGivney has hired a RN weekend manager. 4 DON covers the RN for weekdays and RN manager will cover weekends.**	
F 0730 SS=D Bldg. 00	483.35(d)(7) Nurse Aide Peform Review-12 hr/yr In-Service §483.35(d)(7) Regular in-service education. The facility must complete a performance review of every nurse aide at least once every 12 months, and must provide regular			

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	in-service education based on the outcome of these reviews. In-service training must comply with the requirements of §483.95(g). Based on record review and interview, the facility failed to ensure performance reviews were completed for nurse aides at least every 12 months for 5 of 5 CNAs (Certified Nursing Assistants) reviewed for employee records. (CNA 14, CNA 15, CNA 16, CNA 17, and CNA 10) Finding includes: During a record review, on 9/18/23 at 1:55 p.m., the employee records indicated there were several missing in-services. During an interview, on 9/20/23 at 2:53 p.m., the DON (Director of Nursing) indicated she had not done any performance reviews for CNAs and could not provide any. A current position description, titled "Director of Nursing," created on March 2019 and received from the Executive Director (ED) indicated "...Evaluates the work performance of all nursing personnel...." During an interview, on 9/21/23 at 2:33 p.m., the ED indicated he had no policy for providing staffing performance reviews. 3.1-14(h)(1) 3.1-14(h)(2) 3.1-14(h)(3)	F 0730	**MHCC Plan of Correction 2023** **F-730** **1 the facility failed to ensure performance reviews were completed for nurse aides at least every 12 months for 5 of 5 CNAs (Certified Nursing Assistants) reviewed for employee records.** **2 All staff have the potential to be affected by this deficient practice.** **3 McGivney has implemented performance reviews on their hire date.** **4 CEO will audit for 3 months for 100% accuracy.**	10/27/2023
F 0732 SS=D Bldg. 00	483.35(g)(1)-(4) Posted Nurse Staffing Information §483.35(g) Nurse Staffing Information. §483.35(g)(1) Data requirements. The facility must post the following information on a daily			

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	155855	A. BUILDING 00 B. WING	09/22/2023

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MCGIVNEY HEALTH CARE CENTER	2907 EAST SMOKY ROW CARMEL, IN 46033

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	basis: (i) Facility name. (ii) The current date. (iii) The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: (A) Registered nurses. (B) Licensed practical nurses or licensed vocational nurses (as defined under State law). (C) Certified nurse aides. (iv) Resident census. §483.35(g)(2) Posting requirements. (i) The facility must post the nurse staffing data specified in paragraph (g)(1) of this section on a daily basis at the beginning of each shift. (ii) Data must be posted as follows: (A) Clear and readable format. (B) In a prominent place readily accessible to residents and visitors. §483.35(g)(3) Public access to posted nurse staffing data. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard. §483.35(g)(4) Facility data retention requirements. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater.			
	Based on observation, interview and record review, the facility failed to post nurse staffing information in an area which could be clearly seen for 35 of 35 residents and visitors reviewed for nurse staffing.	F 0732	**MHCC Plan of Correction 2023 F-732** **1 The facility failed to post nurse staffing information in an**	10/27/2023

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	Finding includes: During an observation, on 9/19/23 at 11:10 a.m., there was no posted nurse staffing sheet around the nurse's station or noted in the facility. During an interview, on 9/19/23 at 11:15 a.m., the Activities Director indicated the facility did not post nurse staffing data but kept it in a binder. During an observation, on 9/19/23 at 11:20 a.m., the daily staffing sheet was in a binder behind the nurse's station. The daily staffing sheet was not posted in an area easily visible for residents and visitors. During an interview, on 9/21/23 at 2:33 p.m., the ED (Executive Director) indicated he had no policy about posting nurse staffing but it should be posted in the facility. 3.1-17(b)		**area which could be clearly seen for 35 of 35 residents and visitors reviewed for nurse staffing.** **2 All residents have the potential to be affected by this deficient practice.** **3 McGivney has changed the location of nursing information to across from the nursing station to everyone.** **4 Ed will audit for 3 months for 100% accuracy.**	
F 0760 SS=G Bldg. 00	483.45(f)(2) Residents are Free of Significant Med Errors The facility must ensure that its- §483.45(f)(2) Residents are free of any significant medication errors. Based on interview and record review, the facility failed to ensure a resident received the correct medication for 1 of 1 resident reviewed for a significant medication error. (Resident 20) Resident 20 required an intensive care stay in the hospital for 5 days. Finding includes: The record for Resident 20 was reviewed on	F 0760	**MHCC Plan of Correction 2023 F-760** **1 the facility failed to ensure a resident received the correct medication for 1 of 1 resident reviewed for a significant medication error. Resident 20 required an intensive care stay in the**	10/27/2023

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	9/19/23 at 2:01 p.m. Diagnoses included, but were not limited to, dementia with other behavioral disturbance, bradycardia, abnormal weight loss, mood disorder, chronic pain syndrome, and hypertension. A progress note, dated 6/30/23 at 9:25 am, indicated the resident was noted to be lethargic. The skin was cool to touch, he had increased slurring speech, and his speech was garbled. The provider was notified and requested a transfer to the emergency department. An SBAR (situation, background, assessment, and recommendation form), dated 6/30/23 at 9:36 a.m., indicated the resident had a change in mental status and was given another resident's medications. A hospital patient summary report, dated 6/30/23 at 2:46 pm, indicated the admitting diagnosis was an overdose of antipsychotic accidental or unintentional accidental overdose of beta-adrenergic blocker. The resident was diagnosed with acute toxic encephalopathy (brain disfunction caused by toxic exposure) due to receiving the medications for another resident. Poison control recommended flumazenil (to help the resident wake up after an overdose) which was given in the emergency department. The resident also had a diagnosis of lactic acidosis (too little oxygen reaches body tissues) likely related to medications and poor intake. A diagnosis of sinus bradycardia (low heart rate) resulted from an inadvertent dose of metoprolol tartrate (for high blood pressure and heart rate)100 mg (milligrams). A progress note, from the attending physician in medical intensive care unit, dated 6/30/23 at 12:27		**hospital for 5 days.** **2 All residents have the potential to be affected by this deficient practice.** **3 McGivney has reviewed our nursing orientation.** **4 McGivney will audit the newly orientation qma or nurse for medication administration accuracy.**	

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	155855	A. BUILDING 00 B. WING	09/22/2023

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	p.m., indicated the resident presented from his living facility sedated (sleepy). The resident was given medications which were not his own. These medications included 81 mg (milligrams) of aspirin, 0.5 mg of benztropine (for Parkinson's disease), 10 mg of buspirone (a medication for anxiety), 10 mg of Jardiance (a medication for diabetes), 1 mg lorazepam (a medication for anxiety), 100 mg pimavanserin (for Parkinson's disease), 1 gm (gram) metformin (used for diabetes) and 200 mg Seroquel (used for schizophrenia and bipolar). The resident's medication list included atorvastatin (a cholesterol medication) 40 mg, tamsulosin (for the prostate) 0.4 mg, aspirin 81 mg, Tylenol (for pain) 325 mg as needed, Imodium A-D (for loose stools) 2 mg as needed, and Zyprexa (for behavior disturbance/mood disorder) 5 mg. A progress note, dated 7/5/23 at 2:09 p.m., indicated the resident returned to the facility via stretcher, provider notified of medication changes at this time. Director of nursing notified of return. A medication variance report, dated 6/30/23 at 9:00 a.m., indicated the type of variance was the wrong resident and the reason was failure to identify the resident. Nurse 18 was placed back in orientation. During an interview, on 09/21/23 at 10:13 a.m., the Executive Director indicated he was aware of the significant medication error and the employee was terminated. A current policy, titled "Medication Administration," no date, received from the Executive Director on 9/21/23 at 9:34 a.m., indicated "...licensed or qualified personnel shall be responsible to follow accepted practices of medication administration as per physicians' order...picture or other method deemed			

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	comparable by the facility...if a picture is unavailable, verify resident identity with another staff member and with residents' prior administration...." 3.1-48(c)(2)			
F 0761 SS=D Bldg. 00	483.45(g)(h)(1)(2) Label/Store Drugs and Biologicals §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. Based on observation, interview and record review, the facility failed to ensure by mouth (PO) medications, injectable medications and eye drops were stored separately, medications and food	F 0761	**MHCC Plan of Correction** **2023**F-7611 The facility failed to ensure by mouth (PO) medications, injectable	10/27/2023

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	were not stored together, medications were labeled when opened and glucometers were stored in a separate bag for 2 of 2 medication carts reviewed and 1 of 1 medication rooms reviewed. (long hall cart, short hall cart and the medication room) Findings include: 1. During a medication storage observation, on 9/18/23 at 3:00 p.m., the long hall medication storage cart was observed to have the following: a. One bottle of lidocaine (a numbing injectable medication) was stored with a bottle of eye drops. b. The top drawer of the medication cart had lots of debris, dirt, and a brownish sticky substance all over the bottom. c. There was one glucometer sitting on top of the sticky top drawer and it was not in any type of wrapping or container. d. The bottom drawer on the right had lots of debris and dirt on it. e. The bottom drawer on the left had debris, dirt, and sticky substances on it. 2. During a medication storage observation, on 9/18/23 at 3:10 p.m., the medication storage room was observed to have the following: a. A sticky brown substance all over the bottom of the refrigerator. b. The bottom of the refrigerator had multiple paper cartons of supplements sitting on top of the sticky brown substance. c. There was one clear plastic container of pudding covered with plastic wrap and not dated. d. There was one vial of purified protein derivative (PPD-a testing solution for tuberculosis) opened and not dated. During an interview, on 9/18/23 at 3:15 p.m., LPN 2		medications and eye drops were stored separately, medications and food were not stored together, medications were labeled when opened and glucometers were stored in a separate bag for 2 of 2 medication carts reviewed and 1 of 1 medication rooms reviewed. 2 All residents have the potential to be affected by this deficient practice. 3 McGivney purchased a separate mini fridge on 9/19/23. 4 Unit manager will audit the mini fridges and medication carts for 2 months for 100% accuracy.	

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	indicated the PPD solution was only good for 30 days after being opened and should have been disposed of since it was not dated. 3. During a medication storage observation, on 9/18/23 at 3:20 p.m., the short hall medication storage cart was observed to have the following: a. The top drawer had lots of debris and sticky sediment stuck to the bottom of the drawer and the drawer dividers. b. A glucometer, with no resident name, was sitting directly on top of the dirty top drawer which was visibly soiled with a sticky clear substance on the top of the glucometer. c. One container of hand sanitizer and multiple AA batteries were stored with PO Risperdal (an antipsychotic medication). During an interview, on 9/19/23 at 11:39 a.m., the Director of Nursing (DON) indicated they would need to get another refrigerator to store the pudding and the supplements since they should not be stored with the medications. The glucometers should be stored in a baggy and not directly on the drawer of the medication cart. If the medication drawer had been clean then the glucometer would not have had sticky stuff on it. She was not sure why the facility did not have separate glucometers for each resident. During an interview, on 9/19/23 at 3:20 p.m., the Executive Director (ED) indicated the facility had extra glucometers to use for individual residents for when "state got here" and the staff were just not using them yet. The night shift was supposed to clean the medication carts. There was no policy on cleaning the medication carts as it was just a professional expectation.4. During an observation, on 9/19/23 at 9:46 a.m., there were 2 opened pudding cups in the top drawer of the medication			

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MCGIVNEY HEALTH CARE CENTER	2907 EAST SMOKY ROW CARMEL, IN 46033

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	cart without a date on them. QMA 3 indicated he was unsure how long they were in there. During an interview, on 9/21/23 at 11:27 a.m., the DON (Director of Nursing) indicated there should not be opened pudding cups in the medication drawer without a label on them. During an interview, on 9/21/23 at 2:10 p.m., the RD (Registered Dietician) indicated pudding cups should be refrigerated 2 to 4 hours after they were opened. A current policy, titled "McGivney Health Center Storage of Medications and Biologicals," reviewed and updated on 7/5/17 and received from the ED on 9/19/23 at 3:20 p.m., indicated "...The facility will have a policy to ensure that medications and biologicals are stored safely, securely, and properly, following manufacturer's recommendations or those of the supplier...Internally administered medications are kept separate from orally administered medications...Intravenously administered medications are kept separate from orally administered medications...Eye medications are kept separate from ear medications and inhaler, etc...Potentially harmful substances are clearly identified and stored in an area separate from medications...Once a medication has been opened an Open Date Label must be applied with the date medications was opened...." A current policy, titled "Blood Glucose Monitoring," dated 5/16/2019 and received on 9/20/23 at 3:20 p.m., indicated "...The standard of this practice is for all nursing personnel to have direction and guidance through which services are expected to be the changing nature of health care provision for people with diabetes...Clean			

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	155855	A. BUILDING 00 B. WING	09/22/2023

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	glucometer between each resident and after each finger stick following manufacturer procedures...Store appropriately [i.e. in a storage case, labeled with the resident name if dedicated for individual use]...." 3.1-25(o)			
F 0809 SS=F Bldg. 00	483.60(f)(1)-(3) Frequency of Meals/Snacks at Bedtime §483.60(f) Frequency of Meals §483.60(f)(1) Each resident must receive and the facility must provide at least three meals daily, at regular times comparable to normal mealtimes in the community or in accordance with resident needs, preferences, requests, and plan of care. §483.60(f)(2)There must be no more than 14 hours between a substantial evening meal and breakfast the following day, except when a nourishing snack is served at bedtime, up to 16 hours may elapse between a substantial evening meal and breakfast the following day if a resident group agrees to this meal span. §483.60(f)(3) Suitable, nourishing alternative meals and snacks must be provided to residents who want to eat at non-traditional times or outside of scheduled meal service times, consistent with the resident plan of care. Based on interview and record review, the facility failed to ensure residents were offered bedtime snacks each evening. There was a 15-hour time lapse between the supper meal and breakfast. This deficient practice had the potential to affect 35 of 35 residents who resided in the facility.	F 0809	**MHCC Plan of Correction 2023 F-809** **1 The facility failed to ensure residents were offered bedtime snacks each evening. There was a 15-hour time lapse**	10/27/2023

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	Finding includes: A dining schedule, provided at entrance, indicated the facility supper time was 5:00 p.m., and breakfast was at 8:00 a.m., which was a 15-hour time lapse between these meals. During an interview, on 9/20/23 at 11:00 a.m., CNA 10 indicated the cook on the evening shift would gather a cart of snacks including peanut butter and jelly sandwiches and crackers. The facility staff did not pass out the snacks although they were available for any resident who wanted them. Usually, the residents who wandered and were up all night would get the snacks. During an interview, on 9/20/23 at 11:41 a.m., Resident 6 indicated she did not get a snack at night and the facility staff did not ask her if she wanted a snack. When she did ask for a snack, the staff would tell her they did not have any snacks. During a resident council meeting, on 9/20/23 at 1:53 p.m., the resident council indicated the staff used to pass out snacks at bedtime. They now must ask to get snacks at bedtime and the facility would have sandwiches of peanut butter and jelly, ham, turkey, or bologna at times. Sometimes the sandwiches were not available and then there were no snacks for bedtime. During an interview, on 9/20/23 at 11:34 a.m., the Executive Director (ED) indicated he did not know if the dietician approved the bedtime snacks since the menu indicated "assorted snacks." The facility provided snacks of peanut butter and jelly sandwiches and cold meat sandwiches for the residents. The snacks would be kept behind the nurse's station.		**between the supper meal and breakfast. This deficient practice had the potential to affect 35 of 35 residents who resided in the facility.** **2 All residents have the potential to be affected by this deficient practice.** **3 Activity Director did an audit with resident council for preferences. Snacks offered are implemented into point click care as an order.** **4 Activity Director will audit evening snacks for 2 months for 100% accuracy.**	

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	155855	A. BUILDING 00 B. WING	09/22/2023

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	During an interview, on 9/21/23 at 2:04 p.m., the Registered Dietician (RD) indicated the snacks were not listed on the menu since the food service company provided the menus. She had a list of snacks which would provide protein. The night cook would prep the snacks in the evening and then take them out to the nursing staff. The nursing staff would distribute the snacks in the evenings. The staff were supposed to offer a snack to everyone by going room to room. The facility was to make sure they offered a substantial snack in the evening since there was a 15-hour time lapse between the meals. A current policy, titled "McGivney Health Care Center Food and Nutrition Policy," dated 3/1/17 and received from the ED on 9/18/23 at 10:57 a.m., indicated "...Meal hours shall be scheduled at regular times to assure that each resident receives at least three [3] meals per day. Snacks are available to the residents 24 hours a day. The resident may request snacks as desired, or snacks may be scheduled between meals to accommodate the resident's typical eating patterns...Frequency of meals...The facility will serve at least three [3] meals or their equivalent daily at scheduled times. There will be no more than a fourteen [14] hour span between the evening meal and breakfast...Evening snacks will be offered routinely to all residents not on diets prohibiting bedtime nourishment...Resident will also be offered nutritious snacks if the time span between the evening meal and the next day's breakfast exceeds fourteen [14] hours. Nutritious snacks provide substantive carbohydrates, protein, and calories...The facility will choose the snacks that are served at bedtime. However, the Dietician and Food Services Manager will solicit input from the residents and/or the resident council...."			

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	3.1-21(d) 3.1-21(e)			
F 0812 SS=F Bldg. 00	483.60(i)(1)(2) Food Procurement,Store/Prepare/Serve-Sanitary §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. Based on observation, interview and record review, the facility failed to thaw out meat safely and have the sanitizing solution (used to disinfect tables and counters) bucket levels at the recommended range to kill bacteria. This deficient practice had the potential to affect 35 of 35 residents who received food from the kitchen. Findings include: During the kitchen observation, on 9/17/23 at 11:00 a.m., with the Dietary Staff 19 the following	F 0812	**MHCC Plan of Correction 2023** **F-812** **1 The facility failed to thaw out meat safely and have the sanitizing solution (used to disinfect tables and counters) bucket levels at the recommended range to kill bacteria. This deficient practice had the potential to affect 35 of 35 residents who received food**	10/27/2023

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	were observed: a. The sink contained 2 large plastic bags of frozen chicken. The sink had no cold water in the sink and the chicken was thawing at room temp. b. The red sanitizer bucket was tested three times. Dietary Staff 19 placed a test strip into the bucket and the testing strip did not change colors. She tested the bucket again using a strip from a different container and the testing strip did not change color. She then took a third container, and the testing strip did not change colors. The containers for all three sanitizing solution testing strips indicated the ranges for the solution were numbered 10, 25, 50, 100 and 200 and should be between 50 to 100. During an interview, on 9/17/23 at 11:15 a.m., Dietary Staff 19 indicated the two bags of frozen skinless chicken should not thaw in the sink without cold water. During an interview, on 9/17/23 at 11:22 a.m., Dietary Staff 19 indicated the red bucket contained sanitizing solution and if the sanitizer solution were not at the right strength, it would not kill the bacteria and the residents could get sick. The test strip should be purple and between 50-100 range as shown on the strip container. None of the testing strips turned colors and the test strip should change to purple to indicate the amount of sanitizer was appropriate for cleaning surfaces. A current policy, titled "McGivney Health Care Center Food and Nutrition Policy," dated 3/1/17 and received from the Executive Director on 9/18/23 at 10:57 a.m., indicated "...All equipment, food contact surfaces and utensils shall be washed to remove or completely loosen soils by		**from the kitchen.** **2 All residents have the potential to be affected by this deficient practice.** **3 Dietary Manager in-service dietary staff on sanitization strips. Dietary Manager monthly in service on sanitation, food thawing technique, and check logs.** **4 Dietary employees will become food handler serve safe within 6 months.**	

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	using the manual or mechanical means necessary and sanitized using hot water and/or chemical sanitizing solutions...Sanitizing of environmental surfaces must be performed with one of the following solutions: a. 50-100 ppm chlorine solution...." A current policy, titled "McGivney Health Care Center Food and Nutrition Policy," dated 3/1/17 and received from the Executive Director on 9/18/23 at 10:57 a.m., indicated "...Thawing Frozen Food" 1. Foods will not be thawed at room temperature. Thawing procedures include a. Thawing in the refrigerator in a drip-proof container: b. Submerging the items in cold running water (70 degrees F or below); c. Thawing in a microwave oven and then cooking and serving immediately; or d. Thawing as part of a continuous cooking process...." 3.1-21(i)(3)			
F 0835 SS=E Bldg. 00	483.70 Administration §483.70 Administration. A facility must be administered in a manner that enables it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. Based on interview and record review, the Executive Director (ED) failed to ensure the Director of Nursing (DON) was completing the infection surveillance and antibiotic stewardship for the infection control program, to ensure the facility had policies for infection surveillance and antibiotic stewardship, to ensure policies were reviewed annually, to ensure QAPI (quality assurance and performance improvement) meetings had documentation of items reviewed	F 0835	MHCC Plan of Correction 2023 F-835 1 The Executive Director (ED) failed to ensure the Director of Nursing (DON) was completing the infection surveillance and antibiotic stewardship for the infection control program, to ensure the facility had policies for infection	10/27/2023

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	during the meetings, to ensure the facility was staffed according to the needs listed in the facility assessment and to ensure the facility environment was clean and in good repair. Findings include: 1. During an interview, on 9/19/23 at 11:12 a.m., the Director of Nursing (DON) indicated she did not have an infection control binder. There was no infection surveillance or map of the type of infections at the facility or documentation if there were any trends of infections. She indicated she was not familiar with any type of criteria for the appropriate use of antibiotics and was not familiar with the McGeer's criteria (a standardized guidance for infection surveillance for Long Term Care Facilities and for the appropriate use of antibiotics). She indicated if the McGeer's criteria was in the Infection Preventionist webinar she did not know what to do with the information. She had not been a DON prior to this position and was just going by the "seat of her pants." 2. During an interview, on 9/19/23 at 12:21 p.m., the Executive Director (ED) indicated the facility did not have a policy on antibiotic stewardship or infection surveillance. The facility did not date their policies to show they had reviewed them annually. 3. During an interview, on 9/21/23 at 2:32 p.m., the ED indicated the QAPI met monthly although they only did QAPI reports 4 times a year. They would review falls, urinary tract infections (UTIs), activities and behaviors. They were also looking at staffing. He indicated there were no meeting minutes for the items reviewed. They were looking at falls and would communicate all the information verbally. The QAPI knew if their plan was working		surveillance and antibiotic stewardship, to ensure policies were reviewed annually, to ensure QAPI (quality assurance and performance improvement) meetings had documentation of items reviewed during the meetings, to ensure the facility was staffed according to the needs listed in the facility assessment and to ensure the facility environment was clean and in good repair. 2 All residents have the potential to be affected by this deficient practice. 3 ED will promote RN weekend manager to Infection preventionist and will take over responsibility of antibiotic stewardship. ED will document QAPI. Facility Assessment has been updated to weekend staff numbers. ED and Maintenance will work on environmental cleaning checks once a week. 4 ED will check with weekend manager monthly for completion of antibiotic stewardship. ED and maintenance will walk building for 3 months and document environmental concerns.	

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	if they did not have very many residents to review and did not document the information. There was no documentation about any processes being changed or implementation of new interventions or reports about the effectiveness of the changes. 4. During an interview, on 9/19/23 at 2:53 p.m., the ED indicated the facility assessment showed the need for 24 hours of certified nursing assistant (CNA) coverage during the day and evening shifts. This would be a total of 3 CNAs for the day and evening shifts. If the facility was using agency CNAs, then he would only staff the facility with 2 CNAs for the day and evening shifts since it was a budget issue even though the facility assessment showed the need for 3 CNAs. If the facility was using their staff, then 3 CNAs would be scheduled. 5. During ongoing observations, from 9/17/23 to 9/22/23, there were 2 resident rooms which had scuff marks by the bed, missing trim, patches and spots on the walls, rusty bathroom drains with peeling in the showers and clothes on the ground due to no closet. The dining room had sticky floors, bugs, and debris in the windowsills, multiple torn up and patched areas with miscolored paint outside the dining room, rusted ceiling vents, scuffed baseboards along the room, trash outside in a resident gathering area and a large water spot on the ceiling. During an interview, on 9/20/23 at 11:41 a.m., an environmental tour was done with the maintenance man and the ED. They indicated the baseboards in the dining room could not be painted over and did not have plans for repair. The water spot on the ceiling was there since the maintenance man first started working there. The large areas outside the dining room with patches were done almost weekly due to a resident who			

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MCGIVNEY HEALTH CARE CENTER	2907 EAST SMOKY ROW CARMEL, IN 46033

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	rubs his wheelchair against the wall. The window seals would be cleaned more frequently. The flooring in the dining room was cleaned every day and they were not sure why they were sticky. The trash pickups would be done more frequently. The trim in room 13 was put in but the scuff marks would need to be done later. The shower drains were only replaced when needed. The plastic bin in room 1 was the solution to not having a closet. The areas on the wall in room 18 must have happened recently and would be fixed soon. A current job description, titled "Administrator Job Description," created August 2008, revised October 2012 and received from the Executive Director on 9/21/23 at 2:33 p.m., indicated "...The administrator is responsible for the overall management of the Health Care Facility but shall not function as a departmental supervisor, for example, director of nursing or food supervisor, during the same hours...The administrator is responsible for the overall management of the Gibault Health Care Center but shall not function as a departmental supervisor...Manages the ongoing functions of the facility through employment of adequate numbers of appropriately trained professional and auxiliary personnel and the appropriate delegation of duties...Directs repair and new construction programs...Reviews physical condition of nursing facility and grounds...Maintains compliance with Federal, State, and Local standards for nursing facility operation...Authorizes purchases of major equipment and supplies...Works with the Director of Nursing Services for the development and implementation of facility policy and procedures...." 3.1-13(1) 3.1-13(2)(A)			

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	3.1-13(2)(B) 3.1-13(2)(C) 3.1-13(2)(D)			
F 0842 SS=D Bldg. 00	483.20(f)(5), 483.70(i)(1)-(5) Resident Records - Identifiable Information §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. §483.70(i) Medical records. §483.70(i)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized §483.70(i)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is- (i) To the individual, or their resident representative where permitted by applicable law; (ii) Required by Law; (iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506; (iv) For public health activities, reporting of abuse, neglect, or domestic violence, health			

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	oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512. §483.70(i)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use. §483.70(i)(4) Medical records must be retained for- (i) The period of time required by State law; or (ii) Five years from the date of discharge when there is no requirement in State law; or (iii) For a minor, 3 years after a resident reaches legal age under State law. §483.70(i)(5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50.			
	Based on interview and record review, the facility failed to ensure the Medication Administration Records (MARs) were documented completely to identify if the residents did or did not receive the prescribed medication for 2 of 2 residents reviewed for medication administration	F 0842	MHCC Plan of Correction 2023 F-842 1 The facility failed to ensure the Medication Administration Records (MARs) were	10/27/2023

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	documentation. (Residents 6 and 28) Findings include: 1. The record for Resident 6 was reviewed on 9/20/23 at 2:19 p.m. Diagnoses included, but were not limited to, chronic obstructive pulmonary disorder, depressive disorder, type 2 diabetes mellitus, and anxiety disorder. A MAR, dated for the month of August 2023, indicated the following medications were not signed as administered or not administered: a. Aspirin (Nonsteroidal anti-inflammatory and blood thinner) 81 mg (milligram) one tablet daily on 8/25 and 8/31/23 at 9:00 a.m. b. Cyclobenzaprine (muscle relaxant) HCI 10 mg one tablet daily on 8/25 and 8/31/23 at 9:00 a.m. c. Doxepin (antidepressant) HCI 10 mg one tablet daily on 8/24/23 at 9:00 a.m. d. Famotidine (antacid) 40 mg one tablet daily on 8/25 and 8/31/23 at 9:00 a.m. e. Fluticansone-Umeclidin-Vilant (steroid) inhalation Aerosol 100-62.5-25 mcg/act one inhale daily at 8/25 and 8/31/23 at 9:00 a.m. f. Lasix (diuretic) 20 mg one tablet daily on 8/25 and 8/31/23 at 9:00 a.m. g. Metformin (anti-diabetic med) for blood HCI 500 one tablet daily on 8/25 and 8/31/23 at 9:00 a.m. h. Montelukast Sodium (anti-inflammatory) 10 one tablet on 8/24/23 at 9:00 p.m. i. Venlafaxine HCI (anti-depressant) 75 mg one tablet daily on 8/25 and 8/31/23 at 9:00 a.m. j. Buspirone (anxiolytic) HCI 10 mg one tablet twice a day on 8/25 and 8/31/23 at 9:00 a.m. k. Depakote Sprinkles Delayed Sprinkle (anticonvulsant) one tablet twice a day on 8/25 and 8/31/23 at 9:00 a.m. l. Norco (pain) 5-325mg one tablet twice a day on 8/25 and 8/31/23 at 9:00 a.m.		documented completely to identify if the residents did or did not receive the prescribed medication for 2 of 2 residents reviewed for medication administration documentation. 2 All residents have the potential to be affected by this deficient practice. 3 McGivney Nurses and QMA In-service November 6 about documented after administration of medications and/or treatments. 4 Unit Manager will check and track Nurses and QMA documentation weekly for 3 months with 100% compliance and report back to the QAPI team.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155855	A. BUILDING 00 B. WING	09/22/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
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	m. Acetaminophen (pain) 325 mg two tablets three times a day on 8/19/23 at 2:00 p.m., 8/25 and 8/31/23 at 9:00 a.m. and 2:00 p.m. n. Gabapentin (nerve pain) 600 mg one tablets three times a day on 8/19 and 8/24/23 at 9:00 p.m., 8/25 and 8/31/23 at 9:00 a.m. and 2:00 p.m. 2. The record for Resident 28 was reviewed on 9/19/23 and 3:39 p.m. Diagnoses included, but were not limited to, dementia without behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety disorder. A MAR, dated for the month of July 2023, indicated the following medications were not signed as administered or not administered: a. Buspirone HCI (anxiolytic) 15mg one tablet three times a day on 7/17/23 at 9:00 p.m., and 7/23/23 at 2:00 p.m. b. Depakote DR (delayed release) 125 mg one tablet three times a day on 7/17/23 at 9:00 p.m., and 7/23/23 at 2:00 p.m. d. Sodium chloride 1 gram give one tablet three times a day on 7/17 and 7/23/23 at 9:00 p.m. A MAR, dated for the month of August 2023, indicated the following medications were not signed as administered or not administered: a. Atenolol (high blood pressure) 25 mg one tablet daily on 8/25 and 8/31/23 at 9:00 a.m. b. Colace (stool softener) 100 mg one tablet daily on 8/25 and 8/31/23 at 9:00 a.m. c. Vitamin B (dietary supplement) one tablet twice a day on 8/25 and 8/31/23 at 9:00 a.m. d. Buspirone HCI (anxiolytic) 10 mg one tablet twice a day 8/24/23 at 9:00 p.m., 8/25 and 8/31/23 at 9:00 a.m. e. Depakote (anticonvulsant) 5 mg one tablet daily on 8/24/23 at 9:00 p.m. f. Sodium chloride 1 gram one tablet three times a			

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	day on 8/2/423 at 9:00 p.m. g. Tamsulosin (urinary retention) 0.4 mg one tablet daily on 8/25/23 at 9:00 p.m. A care plan, revised 12/7/22, indicated the resident had impaired cognitive function and impaired thought processes related to dementia diagnoses. The interventions included, but were not limited to, administer medication as ordered. During an interview, on 9/22/23 at 10:32 a.m., the Director of Nursing (DON) indicated the MAR should not have blank spaces and she could call the agency staff and ask if they gave the medication. She really doubted they would remember from back in July and August. They should always sign off the medications on the MAR. A current policy, titled "Medication Administration," no date and received from the Executive Director on 9/21/23 at 9:34 p.m., indicated "...The individual medication administration records (MARs) should be reviewed at the end of medication pass to ensure all ordered medications were administered and all administered does were documented...." 3.1-50(a)(1) 3.1-50(a)(2)			
F 0867 SS=D Bldg. 00	483.75(c)(d)(e)(g)(2)(i)(ii) QAPI/QAA Improvement Activities §483.75(c) Program feedback, data systems and monitoring. A facility must establish and implement written policies and procedures for feedback, data collections systems, and monitoring, including adverse event monitoring. The policies and procedures must include, at a			

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	155855	A. BUILDING 00 B. WING	09/22/2023

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	minimum, the following: §483.75(c)(1) Facility maintenance of effective systems to obtain and use of feedback and input from direct care staff, other staff, residents, and resident representatives, including how such information will be used to identify problems that are high risk, high volume, or problem-prone, and opportunities for improvement. §483.75(c)(2) Facility maintenance of effective systems to identify, collect, and use data and information from all departments, including but not limited to the facility assessment required at §483.70(e) and including how such information will be used to develop and monitor performance indicators. §483.75(c)(3) Facility development, monitoring, and evaluation of performance indicators, including the methodology and frequency for such development, monitoring, and evaluation. §483.75(c)(4) Facility adverse event monitoring, including the methods by which the facility will systematically identify, report, track, investigate, analyze and use data and information relating to adverse events in the facility, including how the facility will use the data to develop activities to prevent adverse events. §483.75(d) Program systematic analysis and systemic action. §483.75(d)(1) The facility must take actions			

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	aimed at performance improvement and, after implementing those actions, measure its success, and track performance to ensure that improvements are realized and sustained. §483.75(d)(2) The facility will develop and implement policies addressing: (i) How they will use a systematic approach to determine underlying causes of problems impacting larger systems; (ii) How they will develop corrective actions that will be designed to effect change at the systems level to prevent quality of care, quality of life, or safety problems; and (iii) How the facility will monitor the effectiveness of its performance improvement activities to ensure that improvements are sustained. §483.75(e) Program activities. §483.75(e)(1) The facility must set priorities for its performance improvement activities that focus on high-risk, high-volume, or problem-prone areas; consider the incidence, prevalence, and severity of problems in those areas; and affect health outcomes, resident safety, resident autonomy, resident choice, and quality of care. §483.75(e)(2) Performance improvement activities must track medical errors and adverse resident events, analyze their causes, and implement preventive actions and mechanisms that include feedback and learning throughout the facility. §483.75(e)(3) As part of their performance improvement activities, the facility must			

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	conduct distinct performance improvement projects. The number and frequency of improvement projects conducted by the facility must reflect the scope and complexity of the facility's services and available resources, as reflected in the facility assessment required at §483.70(e). Improvement projects must include at least annually a project that focuses on high risk or problem-prone areas identified through the data collection and analysis described in paragraphs (c) and (d) of this section. §483.75(g) Quality assessment and assurance. §483.75(g)(2) The quality assessment and assurance committee reports to the facility's governing body, or designated person(s) functioning as a governing body regarding its activities, including implementation of the QAPI program required under paragraphs (a) through (e) of this section. The committee must: (ii) Develop and implement appropriate plans of action to correct identified quality deficiencies; (iii) Regularly review and analyze data, including data collected under the QAPI program and data resulting from drug regimen reviews, and act on available data to make improvements.			
	Based on interview and record review, the facility failed to ensure the Quality Assurance and Performance Review (QAPI) committee had documentation of quarterly meetings, documentation of problem areas identified, documentation of staff feedback regarding identified problems and documentation if the	F 0867	MHCC Plan of Correction 2023 F-867 1 The facility failed to ensure the Quality Assurance and Performance Review (QAPI) committee had documentation of	10/27/2023

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	155855	A. BUILDING 00 B. WING	09/22/2023

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	problems had improved or worsened. Findings include: During an interview, on 9/21/23 at 2:32 p.m., the ED indicated the QAPI meets monthly although they only did QAPI reports 4 times a year. They would review falls, urinary tract infections (UTIs), activities and behaviors. They were also looking at staffing. He indicated there were no meeting minutes for the items reviewed. They were looking at falls and would communicate all the information verbally. There was no documentation about any processes being changed or implementation of new interventions or reports about the effectiveness of the changes. The QAPI meetings were used for the facility clinical meetings since they did not meet for daily or weekly clinical meetings. The facility was not able to provide documentation on facility problems identified through QAPI, root cause analysis of problems, staff feedback, or performance improvement of identified problems. A QAPI program, dated 9/1/22 and received at entrance from the Executive Director (ED), indicated "...The QAPI goals...McGivney Health Care Center will implement a QAPI program designed to identify and correct quality deficiencies, as well as opportunities for improvement, which will lead to improvement in the lives of nursing home residents, through continuous attention to quality of care, quality of life, and resident safety by developing, implementing, and maintaining an effective, comprehensive, data driven QAPI program. The QAPI program may include the following departments: Nursing, Activities, Housekeeping,		quarterly meetings, documentation of problem areas identified, documentation of staff feedback regarding identified problems and documentation if the problems had improved or worsened. 2 All residents have the potential to be affected by this deficient practice. 3 ED will ensure documentation log and documentation notes are completed for QAPI. 4 CEO will audit QAPI for 6 months for 100% accuracy and completion.	

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	Dietary, MDS and Social Services...Scope...Address all systems of care and management practices...Include clinical care, quality of life, and resident choice...Utilize the best available evidence to define and measure indicators of quality and facility goals that reflect processes of care and facility operations that have been shown to be predictive of desired outcomes for residents of this facility...Governance and Leadership...Ensuring the program is ongoing, defined, implemented, maintained, and addresses identified priorities...Ensuring the program identifies and prioritizes problems and opportunities that reflect organizational processes, functions, and services to residents based on performance indicator data, and resident and staff input, and other information...Ensuring corrective actions address gap in systems, and are evaluated for effectiveness...Ensuring the plans and goals are carried out and clearly communicated to all staff...the responsibilities of the QAPI steering committee include...Meeting, at a minimum, quarterly and recording minutes on the QAPI Meeting Minutes template...Feedback, Data Systems, and Monitoring...McGivney will establish performance indicators, which will be a combination of process and outcome measures, for all QAPI-designated goals...Performance thresholds will be set to show gradual trends for improvement...Compliance will be monitored formally through quality measure reports, incident reports, and staff satisfaction, and informally through discussions, observations, staff meetings, brainstorming activities...Data on the following measures will be collected, at a minimum, on a quarterly basis and reported to the QAPI Steering Committee...Quality measures...Input collected from staff, residents, families, and others...Adverse events...Survey results...Grievances...These measures will be			

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	155855	A. BUILDING 00 B. WING	09/22/2023

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	collected and reported in a facility report, which is included in the quarterly updates to the Board of Directors...The facility will use data at every QAPI Steering Committee meeting to ensure performance measures are meeting QAPI goals...The facility will take actions aimed at performance improvement as document in QA Committee meeting minutes and action plans...Performance/success of the actions will be monitored in subsequent QA Committee of sub-committee meetings...The facility will utilize Root Cause Analysis. Chooses actions for change will be linked to the root causes and will be designed to effect change at the systems level...Data will be collected throughout the process and then analyzed to determine the effectiveness of any changes...To ensure improvements are sustained, the effectiveness of performance improvement activities will be monitored in QA Committee meetings..." 3.1-52(b)(1) 3.1-52(b)(2)			
F 0880 SS=E Bldg. 00	483.80(a)(1)(2)(4)(e)(f) Infection Prevention & Control §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements:			

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	155855	A. BUILDING 00 B. WING	09/22/2023

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	§483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident			

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	contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. Based on interview and record review, the facility failed to document an annual review of the infection control policies, to ensure multiple use glucometers were clean and to ensure soiled clothing was not thrown on the floor for 1 of 1 residents reviewed for incontinence care (Resident 6). Findings include: 1. A current policy, titled "COVID-19 Vaccination Requirements," received from the Executive Director (ED) at entrance did not have an effective date or a date reviewed. A current policy, titled "Influenza and Pneumococcal Immunizations," received from the ED at entrance had an effective date of 2016 and no revision or date reviewed. During an interview, on 9/19/23 at 12:21 p.m., the Executive Director (ED) indicated the facility did not date their policies to show they had reviewed them annually.	F 0880	MHCC Plan of Correction 2023 F-880 1 The facility failed to document an annual review of the infection control policies, to ensure multiple use glucometers were clean and to ensure soiled clothing was not thrown on the floor for 1 of 1 residents reviewed for incontinence care (Resident 6). 2 All residents have the potential to be affected by this deficient practice. 3 In-Service staff on infection control policy and procedure. Purchase new glucometer for every resident. 4 DON will ensure glucometers are 1 glucometers to 1 resident for 6 months with 100% accuracy. Unit Manager and Charge Nurse will complete walking rounds for 6 months with	10/27/2023

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	155855	A. BUILDING 00 B. WING	09/22/2023

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	2. During a medication storage observation, on 9/18/23 at 3:00 p.m., the long hall medication storage cart was observed to have the following: a. There was one glucometer sitting on top of the sticky top drawer and it was not in any type of wrapping or container. 3. During a medication storage observation, on 9/18/23 at 3:20 p.m., the short hall medication storage cart was observed to have the following: a. The top drawer had lots of debris and sticky sediment stuck to the bottom of the drawer and the drawer dividers. b. A glucometer, with no resident name, was sitting directly on top of the dirty top drawer which was visibly soiled with a sticky clear substance on the top of the glucometer. During an interview, on 9/19/23 at 11:39 a.m., the Director of Nursing (DON) indicated the glucometers should be stored in a baggy and not directly on the drawer of the medication cart. If the medication drawer had been clean, then the glucometer would not have had sticky stuff on it. She was not sure why the facility did not have separate glucometers for each resident. 4. During an observation, on 9/22/23 at 2:31 p.m., Qualified Medical Assistant (QMA) 11 and Certified Nursing Assistant (CNA) 12 entered the resident's room to provide peri-care. QMA 11 indicated Resident 6 had a strong urine odor. CNA 12 dropped the wet dress on the floor at the foot of the bed. When the staff was finished with the peri-care, they moved the resident's bed back against the wall. The wet dress was left on the floor and under the bed. QMA 11 asked CNA 12 to take the trash out of the trash can. CNA 12 took a trash bag and walked towards the bathroom.		100% accuracy.	

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	155855	A. BUILDING 00 B. WING	09/22/2023

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	The staff was stopped and asked if they missed anything and both the QMA 11 and CNA 12 stood at the side of the bed and did not know what they forgot. The record for Resident 6 was reviewed on 9/20/23 at 2:19 p.m. Diagnoses included, but were not limited to, hemiplegia (paralysis) affecting the right dominant side, depressive disorder, type 2 diabetic mellitus, and anxiety disorder. During an interview, on 9/22/23 at 2:31 p.m., QMA 11 indicated she did not know the dress was on the floor and needed to be placed in a bag and taken to laundry. A current policy, titled "Blood Glucose Monitoring," dated 5/16/2019 and received on 9/20/23 at 3:20 p.m., indicated "...The standard of this practice is for all nursing personnel to have direction and guidance through which services are expected to be the changing nature of health care provision for people with diabetes...Clean glucometer between each resident and after each finger stick following manufacturer procedures...Store appropriately [i.e. in a storage case, labeled with the resident name if dedicated for individual use]...." 3.1-18(b)(1)			
F 0881 SS=E Bldg. 00	483.80(a)(3) Antibiotic Stewardship Program §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements:			

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
MCGIVNEY HEALTH CARE CENTER	2907 EAST SMOKY ROW CARMEL, IN 46033

(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
	§483.80(a)(3) An antibiotic stewardship program that includes antibiotic use protocols and a system to monitor antibiotic use. Based on interview and record review, the facility failed to establish policies and a program for antibiotic stewardship, to monitor the use of antibiotics including the use of standardized tools for the appropriateness of antibiotics prescribed and to have a system of surveillance for residents with repeated urinary tract infections (UTIs) for 2 of 2 residents reviewed for UTIs. (Resident 186 and 32) Finding includes: 1. During the entrance conference, the facility failed to provide a policy on antibiotic stewardship and infection surveillance. The Infection Control binder provided by the facility at entrance was dated 2022 and June 2022 was the last entry in the binder. The facility had monthly logs printed by the pharmacy which included the resident name, type of infection, signs and symptoms, and antibiotic utilized. The log did not include if the infection and signs and symptoms met the standardized criteria for the use of the antibiotic. The log did not include if the antibiotic was appropriate for the culture and sensitivity reports for UTIs. During an interview, on 9/19/23 at 11:12 a.m., the Director of Nursing (DON) indicated she did not have an infection control binder and only had an antibiotic log which was printed out by the pharmacy monthly. She did not have any type of monitoring for infections other than the monthly log printed from the pharmacy. There was no surveillance or map of the type of infections at the facility or documentation if there were any trends	F 0881	MHCC Plan of Correction 2023 F-881 1 The facility failed to establish policies and a program for antibiotic stewardship, to monitor the use of antibiotics including the use of standardized tools for the appropriateness of antibiotics prescribed and to have a system of surveillance for residents with repeated urinary tract infections (UTIs) for 2 of 2 residents reviewed for UTIs. (Resident 186 and 32) 2 All residents have the potential to be affected by this deficient practice. 3 Create an antibiotic stewardship and infection surveillance policy. 4 ED will monitor surveillance book for 2 months for 100% accuracy.	11/03/2023

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	155855	A. BUILDING 00 B. WING	09/22/2023

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	of infections. She indicated she was not familiar with any type of criteria for the appropriate use of antibiotics and was not familiar with the McGeer's criteria (a standardized guidance for infection surveillance for Long Term Care Facilities and for the appropriate use of antibiotics). She indicated if the McGeer's criteria was in the Infection Preventionist webinar she did not know what to do with the information. She had not been a DON prior to this position and was just going by the "seat of her pants." The facility used to have weekly meetings to discuss residents and now they only have monthly QAPI (quality assurance and performance improvement) meetings. The QAPI meetings would only discuss infections if any residents currently had an active infection. If there were any concerns with resident infections, she would communicate the information to the staff by "word of mouth" since it was such a small facility and there was no documentation to show the communication. 2. The record for Resident 186 was reviewed on 9/20/23 at 1:38 p.m. The diagnoses included, but were not limited to, Alzheimer's disease with late onset, urinary tract infection, protein-calorie malnutrition, and anemia in chronic kidney disease. A hospital presenting symptoms details report, dated 7/22/23, indicated the resident had increased confusion. The resident was not eating on his own at the long-term care (LTC) facility as he usually did and had an unwitnessed fall. The emergency department work up showed the resident had an acute on chronic subdural hematoma (usually caused by a head injury which caused blood to pool between the brain and its outermost covering) with 5-millimeter (mm) thickness. The resident's other diagnosis			

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	included, but were not limited to, sepsis secondary to urinary tract infection (UTI) and right chest wall cellulitis, complicated UTI from e. coli (a bacteria normally found in the intestines), an unwitnessed fall, and acute on chronic subdural hematoma. A Hospital Discharge Report, dated 8/3/23, indicated the resident was to take cephalexin (an antibiotic) 250 mg/5 ml oral liquid 10 ml two times a day for 8 days. The discharge report did not indicate if the antibiotic was for the UTI or the chest wall cellulitis. A care plan, dated 8/7/2023, indicated the resident had a UTI. The goal was for the UTI to be resolved without complications by the review date. The interventions included, but were not limited to, check at least every 2 hours for incontinence, encourage adequate fluid intake, give antibiotic therapy as ordered, and to obtain and monitor lab and diagnostic work as ordered. The care plan was not updated to include the resident had a repeat UTI. A urinalysis lab report, dated 8/24/23, indicated the resident's urine was cloudy, amber in color, negative for leukocytes (white blood cells), negative for blood, negative for glucose, negative for ketones. The urinalysis indicated no culture was indicated. The lab report did not show any bacteria in the urine. A progress note, dated 8//28/29 at 8:12 p.m., indicated the labs were reported to the on-call			

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	Nurse Practitioner (NP). New orders were received for Bactrim (an antibiotic) double strength (DS) by mouth for 7 days for a UTI. The pharmacy and Power of Attorney were aware. A physician's order, dated 8/29/23 through 9/4/23, indicated to give Bactrim DS oral tablet 800-160 milligram (mg) one time a day for a urinary tract infection. The facility did not have a review of the antibiotic for the UTI to determine if the standard criteria for the use of the antibiotic was present. A progress note, dated 8/29/23 at 12:10 a.m., indicated the resident began treatment for a UTI. The resident remained afebrile (free from fever). During an interview, the ED indicated a culture and sensitivity report was not completed when the resident was ordered the antibiotic on 8/29/23 and the facility did not know the type of bacteria or organism was responsible for the UTI. 3. The record for Resident 32 was reviewed on 9/19/23 at 11:31 a.m. Diagnoses included, but were not limited to, dementia, depressive episode, psychotic disorder with delusions due to known physiological condition, restlessness and agitation, UTI, and delusional disorders. A progress note, dated 6/28/23 at 11:00 a.m., indicated the resident complained of not feeling well. She indicated she had hit her head and she needed to go to the hospital. A hard area was noted at the side of the temple. Her vital signs were a blood pressure of 128/63, pulse 93 and respirations 20. Increased confusion was noted and a cracked tooth.			

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	A hospital noted, dated 6/28/23, indicated a urinalysis was obtained. The results were positive for nitrites, small amount of leukocyte esterase, slightly cloudy, 6-10 white blood cells, and marked bacteria. There was no urine culture and sensitivity from the urinalysis. A progress note, dated 6/28/23 at 6:44 p.m., indicated the resident returned from the hospital. The orders from the emergency department were cephalexin 500 mg (milligrams) twice daily for 14 days. A physician's order, dated 6/29/23, indicated cephalexin 500 mg twice daily. A urinalysis report, dated 8/10/23 at 4:15 p.m., indicated the urine color was amber, cloudy, had 3 + leukocytes, 6-30 red blood cells, 50 white blood cells, many bacteria, calcium oxalate crystal and mucus. A urine culture report, date 8/12/23 at 4:05 p.m., indicated the bacteria was Escherichia Coli 70, 000 to 99, 000 CFU (viable cells)/ml and ceftriaxone was the most effective antibiotic. A physician's order, dated 8/14/23, indicated ceftriaxone 1 gm (gram) injection. During an interview, on 9/19/23 at 12:21 p.m., the Executive Director (ED) indicated the facility did not have a policy on antibiotic stewardship or infection surveillance. A current job description, titled "Director of Nursing," created March 2019 and received from the ED on 9/20/23 at 3:46 p.m., indicated "...The			

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	Director of Nursing assumes authority, responsibility, and accountability for the delivery of nursing services in the facility...Essential Functions...Establishes, implements, and monitors the infection control program designed to provide a safe, sanitary, and comfortable environment designed to prevent the development and transmission of disease and infection...Prepares or reviews infection control surveillance reports to identify trends and to develop effective actions to control...." 3.1-18(b)(1)(A) 3.1-18(b)(1)(B) 3.1-18(b)(1)(C) 3.1-18(b)(2) 3.1-18(b)(3)			
F 0882 SS=E Bldg. 00	483.80(b)(1)-(4) Infection Preventionist Qualifications/Role §483.80(b) Infection preventionist The facility must designate one or more individual(s) as the infection preventionist(s) (IP)(s) who are responsible for the facility's IPCP. The IP must: §483.80(b)(1) Have primary professional training in nursing, medical technology, microbiology, epidemiology, or other related field; §483.80(b)(2) Be qualified by education, training, experience or certification; §483.80(b)(3) Work at least part-time at the facility; and §483.80(b)(4) Have completed specialized training in infection prevention and control. Based on interview and record review, the facility	F 0882	MHCC Plan of Correction 2023	10/27/2023

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	failed to ensure the Infection Preventionist (IP) was knowledgeable, had completed the facility infection surveillance and antibiotic stewardship documentation, and was not also the acting Director of Nursing (DON) for 1 of 1 Infection Preventionist reviewed. (The DON) Finding includes: During the entrance conference, the Executive Director (ED) provided an IP certificate for the DON which was completed on 6/14/23. During an interview, on 9/18/23 at 4:20 p.m., the ED indicated there was no job description for the IP nurse. The DON job description included the duties of the IP. During an interview, on 9/19/23 at 11:12 a.m., the Director of Nursing (DON) indicated she did not have an infection control binder and only had an antibiotic log which was printed out by the pharmacy monthly. She did not have any type of monitoring for infections other than the monthly log printed from the pharmacy. There was no surveillance or map of the type of infections at the facility or documentation if there were any trends of infections. She indicated she was not familiar with any type of criteria for the appropriate use of antibiotics and was not familiar with the McGeer's criteria (a standardized guidance for infection surveillance for Long Term Care Facilities and for the appropriate use of antibiotics). She indicated if the McGeer's criteria was in the Infection Preventionist webinar she did not know what to do with the information. She had not been a DON prior to this position and was just going by the "seat of her pants." The facility used to have weekly meetings to discuss residents and now they only have monthly QAPI (quality assurance		F-882 1 The facility failed to ensure the Infection Preventionist (IP) was knowledgeable, had completed the facility infection surveillance and antibiotic stewardship documentation, and was not also the acting Director of Nursing (DON) for 1 of 1 Infection Preventionist reviewed. (The DON) 2 All residents have the potential to be affected by this deficient practice. 3 RN weekend manager is our intern Infection Preventionist.	

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	and performance improvement) meetings. The QAPI meetings would only discuss infections if any residents currently had an active infection. If there were any concerns with resident infections, she would communicate the information to the staff by "word of mouth" since it was such a small facility and there was no documentation to show the communication. The facility did not have documentation of trends in facility infections or if the prescribed antibiotics met a standardized criteria for appropriateness of their use. A current job description, titled "Director of Nursing," created March 2019 and received from the ED on 9/20/23, indicated "...The Director of Nursing assumes authority, responsibility, and accountability for the delivery of nursing services in the facility. In collaboration with facility Administrator, allocates department resources in an efficient and economic manner to enable each resident to attain or maintain the highest practical physical, mental, and psychosocial well-being. Collaborates with other departments, medical professionals, consultants, and organizations, including government agencies and advocacy groups, to develop, support and coordinate resident care, related administrative functions, and to represent the interests of the facility...Actively participates in the direct resident care, as and when needed...Develops, maintains, and implements nursing policies and procedures which conform to current standards of nursing practice, facility philosophy, and operational policies while maintaining compliance with state and federal laws and regulations. Ensures facility programs in compliance and prepared for unexpected visits by state and federal governmental agencies...Communicates and			

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	interprets policies and procedures to nursing staff, and monitors staff practices and implementation...Establishes, implements, and monitors the infection control program designed to provide a safe, sanitary, and comfortable environment designed to prevent the development and transmission of disease and infection...Prepares or reviews infection control surveillance reports to identify trends and to develop effective actions to control...."			
F 0883 SS=D Bldg. 00	483.80(d)(1)(2) Influenza and Pneumococcal Immunizations §483.80(d) Influenza and pneumococcal immunizations §483.80(d)(1) Influenza. The facility must develop policies and procedures to ensure that- (i) Before offering the influenza immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv)The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of influenza immunization; and (B) That the resident either received the influenza immunization or did not receive the			

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	influenza immunization due to medical contraindications or refusal. §483.80(d)(2) Pneumococcal disease. The facility must develop policies and procedures to ensure that- (i) Before offering the pneumococcal immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has already been immunized; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv)The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of pneumococcal immunization; and (B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal.			
	Based on interview and record review, the facility failed to ensure a resident received the influenza vaccination after consenting to be vaccinated for 1 of 5 residents reviewed for infection control. (Resident 26) Finding includes: The record for Resident 26 was reviewed on 9/20/23 at 9:21 a.m. Diagnoses included, but were not limited to, Parkinson's disease, dementia, and	F 0883	MHCC Plan of Correction 2023 F-883 1. The facility failed to ensure a resident received the influenza vaccination after consenting to be vaccinated for 1 of 5 residents reviewed for infection control. (Resident 26) 2. All residents have the potential to be affected by this deficient	10/27/2023

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	heart disease. The record did not show he had received an influenza vaccine in 2022. An influenza vaccine consent was received by the resident's representative and was signed on 2/2/22. During an interview, on 9/20/23 at 10:54 p.m., the ED (Executive Director) indicated the resident did sign a consent for the 2022 influenza vaccine. He did not receive the vaccine because he "slipped through the cracks." During an interview, on 9/21/23 at 2:33 p.m., the ED indicated he did not have a policy on providing influenza vaccinations to residents. A current policy, titled "Influenza and Pneumococcal Immunizations," effective date 2016 and received at entrance conference indicated "...The resident's medical record includes documentation that indicates, at a minimum, the following...That the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindication or refusal...." 3.1-18(b)(5)		practice. 3. Influenza was added to the care plan audit for quarterly assessments. 4. Social Services will audit and present findings to the IDT clinical team weekly.	
F 0887 SS=D Bldg. 00	483.80(d)(3)(i)-(vii) COVID-19 Immunization §483.80(d) (3) COVID-19 immunizations. The LTC facility must develop and implement policies and procedures to ensure all the following: (i) When COVID-19 vaccine is available to the facility, each resident and staff member is offered the COVID-19 vaccine unless the			

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	immunization is medically contraindicated or the resident or staff member has already been immunized; (ii) Before offering COVID-19 vaccine, all staff members are provided with education regarding the benefits and risks and potential side effects associated with the vaccine; (iii) Before offering COVID-19 vaccine, each resident or the resident representative receives education regarding the benefits and risks and potential side effects associated with the COVID-19 vaccine; (iv) In situations where COVID-19 vaccination requires multiple doses, the resident, resident representative, or staff member is provided with current information regarding those additional doses, including any changes in the benefits or risks and potential side effects associated with the COVID-19 vaccine, before requesting consent for administration of any additional doses; (v) The resident, resident representative, or staff member has the opportunity to accept or refuse a COVID-19 vaccine, and change their decision; (vi) The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident representative was provided education regarding the benefits and potential risks associated with COVID-19 vaccine; and (B) Each dose of COVID-19 vaccine administered to the resident; or (C) If the resident did not receive the COVID-19 vaccine due to medical contraindications or refusal; and (vii) The facility maintains documentation related to staff COVID-19 vaccination that			

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	includes at a minimum, the following: (A) That staff were provided education regarding the benefits and potential risks associated with COVID-19 vaccine; (B) Staff were offered the COVID-19 vaccine or information on obtaining COVID-19 vaccine; and (C) The COVID-19 vaccine status of staff and related information as indicated by the Centers for Disease Control and Prevention's National Healthcare Safety Network (NHSN). Based on record review and interview, the facility failed to ensure a facility employee had documentation of receiving the Covid-19 vaccination or had obtained an exemption for the vaccine for 1 of 3 employees reviewed for Covid-19 vaccinations. (Activity Director) Finding includes: The Activity Director's record was reviewed on 9/20/23 at 9:21 a.m., which indicated the Activities Director did not have the Covid-19 vaccine or had documentation supporting refusal for the vaccine. During an interview, on 9/20/23 at 11:07 a.m., the ED (Executive Director) indicated the Activities Director was not Covid-19 vaccinated and did not have any documentation to support refusal or education for the vaccination. A current policy, titled "COVID-19 Vaccination Requirements" received at entrance conference, indicated "...Providers participating in Medicare and Medicaid programs must ensure staff are fully vaccinated for COVID-19, unless exempt...." 3.1-18(b)(6)	F 0887	MHCC Plan of Correction 2023 F-887 1 The facility failed to ensure a facility employee had documentation of receiving the Covid-19 vaccination or had obtained an exemption for the vaccine for 1 of 3 employees reviewed for Covid-19 vaccinations. 2 All residents have the potential to be affected by this deficient practice. 3 Covid vaccination will be offer and educated at time of orientation. 4 ED will audit staff roster monthly for 100% completion for 6 months.	10/27/2023

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F 0912 SS=D Bldg. 00	483.90(e)(1)(ii) Bedrooms Measure at Least 80 Sq Ft/Resident §483.90(e)(1)(ii) Measure at least 80 square feet per resident in multiple resident bedrooms, and at least 100 square feet in single resident rooms; Based on observation, interview and record review, the facility failed to provide at least 80 square feet (sq. ft.) per resident in 1 of 18 rooms. (Room 1) Finding includes: During the entrance conference, on 9/17/23 at 1:07 p.m., the Executive Director indicated there had been no physical changes to the room which had a previous room waiver since the last survey on 7/26/22. He indicated Room 1 had two beds, two residents, and currently had a waiver. During an observation, on 9/18/23 at 3:26 p.m., Room 1 was found to have 2 beds. It was noted two residents were occupying the room. A review of the facility measurements for Room 1 indicated the bedroom did not provide 80 square feet per resident. Room 1 was 153.83 sq. ft., and according to Life Safety Code the double occupancy in Room 1 measured out to 76.9 sq. ft. per resident. A "Bed Inventory" form indicated Room 1 was a Title 19 NF (Medicaid) room and was certified for two resident beds. Facility documentation of a room size certification indicated the following: Room 1, 2 beds/NF, 153.83 Sq.Ft/76.9 Sq.Ft for each resident. 3.1-19(l)(2)(A)	F 0912		

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	155855	A. BUILDING 00 B. WING	09/22/2023

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F 0921 SS=D Bldg. 00	483.90(i) Safe/Functional/Sanitary/Comfortable Environ §483.90(i) Other Environmental Conditions The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. Based on observation and interview, the facility failed to ensure resident rooms and the dining room were clean, painted, and free of debris and dirt for 4 of 36 rooms and 1 of 1 dining room reviewed for environment. (Room 18, 1, 11, 13, and dining room) Findings include: 1. During an observation, on 9/17/23 at 1:55 p.m., the wall in Room 18 had 4 brown round areas and 2 patches near the resident head of the bed which were painted the wrong color. 2. During an observation, on 09/17/23 at 11:23 a.m., Room 1 had no closet in the room. There was a clothes basket and belongings on the floor in the room. There was 1 small 2-layer plastic bin for some clothes. 3. During an observation, on 9/18/23 at 3:25 p.m., Room 11's-bathroom shower had a rusty drain and 3 spots where the shower floor was peeled. 4. During an observation, on 9/17/23 at 12:44 p.m., Room 13 had approximately 2-foot black scuffs mark under the windows and missing trim by the closet. 5. During an observation, on 9/18/23 at 12:11 p.m., there was a bag of trash outside in an area where residents could gather. 6. During an observation, on 9/18/23 at 11:58 a.m.,	F 0921	MHCC Plan of Correction 2023 F-921 1 The facility failed to ensure resident rooms and the dining room were clean, painted, and free of debris and dirt for 4 of 36 rooms and 1 of 1 dining room reviewed for environment. (Room 18, 1, 11, 13, and dining room) 2 All residents have the potential to be affected by this deficient practice. 3 Housekeeping is cleaning facility daily. 4 Department heads will walk around facility once a month to make sure facility is in good, clean environmental shape.	10/27/2023

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	the dining room had dead bugs and debris in the windowsills, scuffed baseboards around the entire room, sticky floors by the bathroom and the vanity trim in the bathroom was torn up and had missing paint at the bottom. 7. During an observation, on 9/19/23 at 11:56 a.m., there were rusted ceiling vents, a large water spot with lint hanging from the ceiling and multiple large areas outside the dining room with patches in the walls which did not match the wall paint color. During an interview, on 9/20/23 at 11:41 a.m., an environmental tour was done with the maintenance man and the ED (Executive Director). They indicated the baseboards in the dining room could not be painted over and did not have plans for repair. The water spot on the ceiling was there since the maintenance man first started working there. The large areas outside the dining room with patches were done almost weekly due to a resident who rubs his wheelchair against the wall. The window seals would be cleaned more frequently. The flooring in the dining room was cleaned every day and they were not sure why they were sticky. The trash pickups would be done more frequently. The trim in Room 13 was put in but the scuff marks would need to be done later. The shower drains are only replaced when needed. The plastic bin in Room 1 was the solution to not having a closet. The areas on the wall in Room 18 must have happened recently. A policy, titled "Resident Rights Know Your Rights under Federal Nursing Home Regulations," updated on 3/15/17 and received from the ED on 9/21/23 at 12:13 p.m., indicated "...You have the right to a safe, clean, comfortable and homelike environment, including but not limited to			

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	receiving treatment and supports for daily living safely...." 3.1-19(f)(5)			
F 9999 Bldg. 00	Sec. 1.4. (a) Each facility shall have specific procedures written and implemented for the screening of prospective employees. Appropriate inquiries shall be made for prospective employees. The facility shall have a personnel policy that considers references and any convictions in accordance with IC 16-28-13-3. p) Initial orientation of all staff must be conducted and documented and shall include the following: (1) Instructions on the needs of the specialized population or populations served in the facility, for example: (A) aged; (B) developmentally disabled; (C) mentally ill; (D) children; or (E) care of cognitively impaired; residents. (2) A review of residents' rights and other pertinent portions of the facility's policy manual. (3) Instruction in first aid, emergency procedures, and fire and disaster preparedness, including evacuation procedures and universal precautions. (4) A detailed review of the appropriate job description, including a demonstration of equipment and procedures required of the specific position to which the employee will be assigned. (5) Review of ethical considerations and confidentiality in resident care and records. (6) For direct care staff, instruction in the particular needs of each resident to whom the employee will be providing care.	F 9999	MHCC Plan of Correction 2023 F-9999 1. Each facility shall have specific procedures written and implemented for the screening of prospective employees. Appropriate inquiries shall be made for prospective employees. The facility shall have a personnel policy that considers references and any convictions in accordance with IC 16-28-13-3. 2. All residents have the potential to be affected by this deficient practice. 3. ED will do an audit of employees records. Resident Rights will be separated with their own inservice during orientation. 4. ED will correct employee records in next 30 days.	11/08/2023

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	(t) A physical examination shall be required for each employee of a facility within one (1) month prior to employment. The examination shall include a tuberculin skin test, using the Mantoux method (5 TU PPD), administered by persons having documentation of training from a department-approved course of instruction in intradermal tuberculin skin testing, reading, and recording unless a previously positive reaction can be documented. The result shall be recorded in millimeters of induration with the date given, date read, and by whom administered. The tuberculin skin test must be read prior to the employee starting work. The facility must assure the following: (1) At the time of employment, or within one (1) month prior to employment, and at least annually thereafter, employees and nonpaid personnel of facilities shall be screened for tuberculosis. For health care workers who have not had a documented negative tuberculin skin test result during the preceding twelve (12) months, the baseline tuberculin skin testing should employ the two-step method. If the first step is negative, a second test should be performed one (1) to three (3) weeks after the first step. The frequency of repeat testing will depend on the risk of infection with tuberculosis. (3) The facility shall maintain a health record of each employee that includes: (A) a report of the preemployment physical examination (u) In addition to the required in-service hours in subsection (l), staff who have regular contact with residents shall have a minimum of six (6) hours of dementia-specific training within six (6) months of initial employment, or within thirty (30) days for personnel assigned to the Alzheimer's and dementia special care unit, and three (3) hours			

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	annually thereafter to meet the needs or preferences, or both, of cognitively impaired residents and to gain understanding of the current standards of care for residents with dementia. This state rule is not met as evidenced by: Based on interview and record review, the facility failed to ensure the staff's annual in-services for resident rights, dementia care and abuse in-services were completed and failed to ensure employees received TB (tuberculosis) vaccinations and/or annual risk assessments for 10 of 10 employees reviewed for employee records. (Activity Director, Dietary Staff 4, Licensed Practical Nurse 2, Qualified Medication Aide 3, Licensed Practical Nurse 7, Activities Staff 9, Licensed Practical Nurse 8, Activities Staff 6, Certified Nursing Assistant 14, and the Minimum Data Set Director) Findings include: 1. During a record review, on 9/18/23 at 1:55 p.m., the employee records indicated the following: a. The Activity Director did not have a resident rights in-service completed. b. Dietary Staff 4 did not have a resident rights in-service completed. c. LPN (Licensed Practical Nurse) 2 did not have a dementia care in-service completed. d. QMA (Qualified Medication Aide) 3 did not have a dementia care in-service completed. e. LPN 7 did not have resident rights, dementia care or abuse in-services completed. f. Activities Staff 9 did not have resident rights, dementia care or abuse in-services completed. g. LPN 8 did not have a resident rights in-service completed. h. Activities Staff 6 did not have resident rights or			

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	abuse in-services completed. During an interview, on 9/18/23 at 3:05 p.m., the ED (Executive Director) indicated there were missing in-services, and he gave all the documentation he had. During an interview, on 9/21/23 2:33 p.m., the ED indicated he had no policy for providing resident rights, dementia care, or abuse in-services. 2. During a record review, on 9/18/23 at 1:55 p.m., 10 employees were reviewed for TB testing. The employee records indicated there were 5 missing 1st step TB tests, 8 missing 2nd step TB tests, and 10 missing annual TB risk assessments. During an interview, on 9/18/23 at 3:05 p.m., the ED indicated he knew there were missing employee TB testing and the annual risk assessments were not done. During an interview, on 9/21/23 2:33 p.m., the ED indicated he had no policy for providing employee TB testing or doing annual risk assessments.			