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	09/27/2022

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 the Investigation of Complaints IN00390886 and IN00388916. This visit also included a COVID-19 Focused Infection Control Survey. Complaint IN00390886 - Substantiated. Federal/state deficiencies related to the allegations are cited at F580, F689 and F880. Complaint IN00388916- Substantiated. Federal/state deficiencies related to the allegation are cited at F727. Survey dates: September 26 and 27, 2022 Facility number: 000545 Provider number: 155855 AIM number: 100267350 Census Bed Type: SNF/NF: 34 Total: 34 Census Payor Type: Medicare: 2 Medicaid: 32 Total: 34 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review was completed on October 3, 2022.	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			

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

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determin other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclo days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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	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 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			

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	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). Based on interview and record review, the facility failed to notify the responsible party of an unwitnessed fall for 1 of 3 residents reviewed for notification of a change in condition related to a fall. (Resident C) Finding includes: The record for Resident C was reviewed on 09/25/22 at 2:25 p.m. Diagnoses included, but were not limited to, dementia with behavioral disturbance, Parkinson's disease and schizophrenia. A nursing note, dated 09/25/22 at 1:55 p.m., indicated "...resident was sitting on the floor in room. resident indicated that is was not a fall. also indicated that he didn't put himself there...." A nursing note, dated 09/25/22 at 2:38 p.m., indicated "...resident was sitting on floor resident stated that he did not fall. no injuries noted. vitals within normal limits...." There was no documentation found, in the record to indicate the POA had been notified of the fall. During a telephone interview, on 09/26/22 at 2:31 p.m., Resident C's Responsible Party and Power of Attorney (POA) indicated she had not received any calls from the facility recently to indicate there was any change in condition or falls.	F 0580	F- 580 1. The facility failed to ensure resident family was notified of a unwitnessed fall. 2. All residents have the potential to be affected by this deficient practice. 3. The facility has updated the agency book with instruction on what to do during an unwitnessed or witness fall. 4. Unit Manager will check agency book the following day to make sure the agency nurse signed off she read the agency book.	10/27/2022

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	During an interview, on 09/27/22 at 11:00 a.m., the Executive Director indicated Resident C being found on the floor was an unwitnessed fall. He was notified of the fall and was informed the agency nurse was educated on the proper way to handle a fall, to include contacting the family/responsible party, however the responsible party was not notified. During an interview, on 9/27/22 at 3:06 p.m., LPN 3 indicated when a resident fell the family was to be notified and it was to be documented in the resident record on the SBAR (Situation-Background-Assessment-Recommendation: a communication tool) and the nursing note. During the interview, LPN 3 reviewed the record. She was unable to find the SBAR tool or documentation to show the family/POA was notified. A current facility policy, titled "Physician Notification of Change," undated and provided by the Executive Director on 09/27/22 at 12:25 p.m., indicated "...The following are examples of changes in condition...Fall with or without injury...the Nurse is responsible to notify a family member or responsible party...." This Federal tag relates to Complaint IN00390886. 3.1-5(a)(2)			
F 0689 SS=D Bldg. 00	483.25(d)(1)(2) Free of Accident Hazards/Supervision/Devices §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is			

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	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 complete a neurological assessment after an unwitnessed fall for 1 of 3 residents reviewed for accidents. (Resident C) Finding includes: The record for Resident C was reviewed on 09/25/22 at 2:25 p.m. Diagnoses included, but were not limited to, dementia with behavioral disturbance, Parkinson's disease and schizophrenia. A nursing note, dated 09/25/22 at 1:55 p.m., indicated "...resident was sitting on the floor in room. resident indicated that is was not a fall. also indicated that he didn't put himself there...." A nursing note, dated 09/25/22 at 2:38 p.m., indicated "...resident was sitting on floor resident stated that he did not fall. no injuries noted. vitals within normal limits...." An undated and untitled facility document, provided by the Executive Director on 09/26/22 at 12:36 p.m., indicated "...Un-witnessed...9/25/2022...Incident Location...Resident's Room...Nursing Description: resident on floor sitting up...." A facility document, titled "Neurological Flow Sheet," provided by the Executive Director on 09/27/22 at 1:28 p.m., indicated "...Vital Signs and Neuro Checks...q (every) 15 mins. (minutes) x (1) hour...q 30 mins x (1) hour...q 1 hour x (4)	F 0689	F- 689 1. The facility failed to complete neurological assessments for unwitnessed fall. 2. All residents have the potential to be affected by this deficient practice. 3. The facility has updated the agency book with instruction on what to do during an unwitnessed or witness fall for neurological assessments. 4. Unit Manager will check agency book the following day to make sure the agency nurse signed off she read the agency book and neurological assessments were completed.	10/24/2022

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	hours...then...q 4 hours x (24) hours...(Progress along this time schedule ONLY if signs are stable)...." The document indicated the assessments were completed on 09/25/22 at 2:00 p.m., 09/25/22 at 2:15 p.m., 09/25/22 at 2:30 p.m. and 09/25/22 at 2:45 p.m. There was no further documentation to show the neurological checks had been completed per the directions on the form. During an interview, on 09/27/22 at 11:00 a.m., the Executive Director indicated Resident C having been found on the floor, was an unwitnessed fall. During an interview, on 9/27/22 at 3:06 p.m., LPN 4 indicated when a resident fell and it was unwitnessed, neuro-checks (an assessment of motor and sensory skills, balance and coordination, mental status, reflexes, and functioning of the nerves) were to be completed per the scheduled intervals on the neuro-check sheet. During the exit conference, on 09/27/22 beginning at 3:59 p.m., LPN 4 indicated the neuro checks had not been completed and needed to be completed. A current facility policy, titled "Falls and Fall Risk Managing," undated and provided by the Executive Director on 09/27/22 at 12:25 p.m., indicated "...A fall without injury is still a fall...when a resident is found on the floor, a fall is considered to have occurred...." This Federal tag relates to Complaint IN00390886. 3.1-45(a)(2)			

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F 0727 SS=F 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 observation, interview and record review, the facility failed to ensure a Registered Nurse (RN) was on site for 8 hours a day for 60 of 63 days from July 27, 2022 to September 27, 2022. This deficient practice had the potential to effect 34 of 34 residents residing in the facility. Finding includes: During the Entrance Conference, on 09/26/22 at 9:56 a.m., the Executive Director indicated the facility had not had a Director of Nursing since July 2022, when the Director of Nursing was terminated. The facility had a RN but the nurse was injured about two (2) weeks ago and had not been in the facility. The registered nurse was PRN (as needed), not a full time employee. The time punches of RN coverage were requested in the conference. On 09/27/22 at 12:25 p.m., the Executive Director provided, on a piece of paper, a hand written list	F 0727	F- 727 1. The facility failed to have a RN present for 8 hours a day. 2. All residents have the potential to be affected by this deficient practice. 3. The facility is in negotiations for RN consultants to meet the requirements.	10/31/2022

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	of RN coverage times. The document indicated the facility had a Registered Nurse on duty 07/29/22 for 9 hours, 08/12/22 for 7.75 hours, 08/13/22 for 7.75 hours, 08/30/22 for 8.25 hours and 09/03/22 for 4 hours. The facility was unable to provide documentation to show a Registered Nurse was on duty for 8 hours daily for 60 of 63 days from July 27, 2022 to September 27, 2022. There was no Director of Nursing or Registered Nurse observed on duty during the survey period of September 26, 2022 to September 27, 2022. During an interview, on 09/26/22 at 9:00 a.m., LPN 1 indicated the facility did not have a Director of Nursing and the Registered Nurse was not on duty. A current facility policy, titled "Nursing Staffing Hours," with an effective date of 2020 and provided by the Executive Director on 09/27/22 at 2:55 p.m., indicated "...The requirements for long-term care facilities require a skill nursing facility provide 24-hour licensed nursing services, an RN/LPN for 8 consecutive hours a day, 7 days a week...and there will be an RN designated as Director of Nursing on a full time basis...." This Federal tag relates to Complaint IN00388916. 3.1-17(b)(3)			
F 0880 SS=D 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			

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	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: §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			

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	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 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 observation, interview and record review, the facility failed to develop and implement written policies and procedures for infection control, to contain the spread of infections including the Covid-19 virus, when the facility failed to ensure staff wore face masks appropriately for 4 of 4 randomly observed staff members. (CNA 2, QMA 3, LPN 4 and Housekeeping Staff 5) Findings include: During an observation, on 09/26/22 at 9:03 a.m., CNA 2 was observed in the long hall, with	F 0880	F- 880 1. The facility failed to have employees develop and implement written policies and procedures for infection control. 2. All residents have the potential to be affected by this deficient practice. 3. McGivney has updated their policy based on Hamilton county community transmission levels and will also educate staff on McGivney updated mask wearing	10/25/2022

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	residents present, without a mask on. At that time, when asked about the mask policy, CNA 2 indicated "Don't know". During an observation, on 09/26/22 at 9:05 a.m., QMA 3 and CNA 2 were observed standing in close proximately, in a small room at the nursing station. QMA 3 had a mask worn below his chin and CNA 2 was not wearing a mask. At that time, QMA 3 indicated masks were to be worn in the building. Immediately following the interview, CNA 2 was observed to leave the nursing station and walk through a group of residents and down the long hall. She was not wearing a mask. During an observation, on 09/26/22 at 12:45 p.m., LPN 4 was observed at the nursing desk without a mask. At that time, when asked about the mask, she indicated "I know". During an observation, on 09/26/22 at 12:49 p.m., Housekeeper 5 was observed in the hall with four residents less than six (6) feet from her. She was observed to be wearing her mask below her nose. At that time, when she was asked about the policy for mask use in the facility she indicated she did not know. During an observation, on 09/27/22 at 8:58 a.m., CNA 2 was observed sitting at the nursing station with a resident standing behind her. She was not wearing a mask. The policy for mask usage was requested of the Executive Director. A policy, titled "COVID-19 Vaccination Requirements," was provided by the Executive Director on 09/26/22 at 12:30 p.m. At that time, he indicated it was the mask policy. A current facility policy, titled "COVID-19		policy depending on Hamilton county community level on Oct 25. 4. McGivney executive director will check community transmisson level weekly. Executive Director will complete daily visual rounds throughout the facility to ensure staff are practicing appropriate Infection Control Practices and complying with the solutions. This will occur for 6 weeks and until compliance is maintained. D. Quality Assurance and Performance Improvement (QAPI): 1. The facility through the QAPI program, will review, update and make changes to the DPOC as needed for sustaining substantial compliance for no less than 6 months.	

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	Vaccination Requirement," undated and provided by the Executive Director on 09/26/22 at 12:30 p.m., indicated "...Masking when working indoors...." This Federal tag relates to Complaint IN00390886. 3.1-18(b)			