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	07/26/2022

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

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F 0000 Bldg. 00	This visit was for a Recertification and State Licensure Survey. Survey dates: July 19, 20, 21, 22, 25 and 26, 2022. Facility number: 000545 Provider number: 155855 AIM number: 100267350 Census Bed Type: SNF/NF: 31 Total: 31 Census Payor Type: Medicare: 1 Medicaid: 30 Total: 31 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review was completed on August 3, 2022.	F 0000		
F 0578 SS=D Bldg. 00	483.10(c)(6)(8)(g)(12)(i)-(v) Request/Refuse/Dscntnue Trmnt;Formlte Adv Dir §483.10(c)(6) The right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. §483.10(c)(8) Nothing in this paragraph should be construed as the right of the resident to receive the provision of medical treatment or medical services deemed medically unnecessary or inappropriate.			

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

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	§483.10(g)(12) The facility must comply with the requirements specified in 42 CFR part 489, subpart I (Advance Directives). (i) These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the resident's option, formulate an advance directive. (ii) This includes a written description of the facility's policies to implement advance directives and applicable State law. (iii) Facilities are permitted to contract with other entities to furnish this information but are still legally responsible for ensuring that the requirements of this section are met. (iv) If an adult individual is incapacitated at the time of admission and is unable to receive information or articulate whether or not he or she has executed an advance directive, the facility may give advance directive information to the individual's resident representative in accordance with State Law. (v) The facility is not relieved of its obligation to provide this information to the individual once he or she is able to receive such information. Follow-up procedures must be in place to provide the information to the individual directly at the appropriate time. Based on record review and interview, the facility failed to maintain accurate documentation of a code status when a resident's care plan was not in agreement with the code status documented in the physician orders for 1 of 12 residents reviewed for advanced directives. (Resident 5) Finding includes:	F 0578	McGivney Health Care Center Social Services 2022 Plan of Correction 1. (F-578) a. The McGivney Health Care Center (MHCC) Social Services Director is designated as the employee responsible for care	08/17/2022

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	The record for Resident 5 was reviewed on 07/20/22 at 2:47 p.m. Diagnoses included, but were not limited to, dementia, COPD (Chronic Obstructive Pulmonary Disorder), anxiety disorder and chronic kidney disease. A Social Service progress note, dated 03/22/22 at 10:00 a.m., indicated Resident 5 had a care plan meeting (a meeting with the nursing, Social Services, dietary and activities as well as the resident and resident's family or POA (Power Of Attorney) to discuss care, new wishes and concerns) with the resident's daughter/POA in attendance. At that time, the resident's daughter indicated she wanted to change her mother's code status to DNR (do not resuscitate). An Indiana Physician Orders For Scope Of Treatment (Post) document, signed and dated by the resident's POA, on 04/05/22, indicated if Resident 5 had no pulse AND was not breathing do not attempt resuscitation/DNR. A physician's order, dated 05/27/22, indicated DNR. An undated care plan indicated Resident 5 and her family preferred full code status. Interventions included, but were not limited to, respect new code status preference and update the care plan if Resident 5 and her family identified change in preference for code status during quarterly review. A care plan, initiated on 07/21/22, indicated Resident 5 and her family prefer DNR code status. During an interview, on 07/21/22 at 11:50 a.m., the Social Service Director indicated the resident did have a care plan in place which indicated her		planning and updating code status in the electronic chart. i. The SSD will immediately create resident centered comprehensive care plans for code status for resident. ii. The SSD will complete a care plan audit to identify other MHCC residents needing resident centered comprehensive care plans for code status by 8/17/22 iii. Needed updates to resident care plans related to code status will be completed by 8/17/22. iv. The SSD will ensure that appropriate updates are made to all resident centered care plans for code status and audit quarterly. 1. The SSD will maintain a log documenting quarterly review of each resident's centered comprehensive care plans for the resident's code status. a. The log will contain notation of dates that each resident's quarterly review was completed and which, if any, updates were made to resident centered comprehensive care plan related to code status. b. Documentation of adherence to this Plan of Correction will be reviewed with QA/QI, monthly.	

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	families preference for the resident was to be a full code. The care plan should have been revised in March to indicate her families new preference for the resident to be a DNR as discussed at her care plan meeting. An, undated, document, titled "Consent/Declination to Resuscitate," provided by the Director of Admissions and Marketing on 07/27/22 at 1:45 a.m., indicated "... McGivney Health Care Center is committed to honoring a resident decision...of my advance directives relating to my health care needs...." 3.1-4(f)(5)			
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 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).			

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	(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).			
	Based on interview and record review, the facility failed to notify the physician of a blood sugar outside the call parameters (Resident 10) and failed to notify the guardian when a resident was transferred to the hospital (Resident 183) for 2 of 2 residents reviewed for notification of change. Findings include: 1. The record for Resident 10 was reviewed on 07/21/22 at 10:22 a.m. Diagnoses included, but were not limited to, dementia with behavior	F 0580	MHCC Plan of Correction 2022 F-580- Failure to Notify 1. The facility failed to notify the MD about Resident #10's low blood sugar and failed to notify Resident #183's guardian when the resident was transferred to the hospital. 2. All residents have the potential to be affected by this deficient practice.	08/17/2022

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	disturbance, Parkinson's disease and type 2 diabetes mellitus. A physician's order, initiated on 09/09/2019, indicated to monitor the blood sugar before meals and at bedtime. Call the physician if the blood sugar was below 70 or over 350. A blood sugar result of 66 was recorded on 05/07/22 at 8:56 p.m. There was no documentation found in the record to show the physician had been notified of the low blood sugar. During an interview, on 07/22/22 at 11:33 a.m., the Unit Manager indicated the physician was to be notified of changes in condition, to include blood sugars outside of the parameters set by the physician's order. The Unit Manager was unable to find documentation to show the physician was notified of a low blood sugar for Resident 10. 2. The record for Resident 183 was reviewed on 07/20/22 at 2:36 p.m. Diagnoses included, but were not limited to, Alzheimer's disease with late onset, malignant neoplasm of prostate and restlessness and agitation. A nursing note, dated 07/20/22, indicated Resident 183 was sent out to the hospital for a flushed red face and a temperature of 99.9 degrees Fahrenheit. It further indicated the guardian and DON (Director of Nursing) were notified. During a telephone interview, on 07/21/22 at 3:46 p.m., the legal guardian of Resident 183 indicated she was not made aware the resident was sent to the hospital on 07/20/22, she was concerned and was going to contact the facility.		3. An In-Service Training was completed on 8/17/22 regarding the Notification of Change in Condition Policy. 4. MHCC will continue to update the agency book about Notification of Change Policy (Must notify MD, DON and Unit Manager regarding change in condition).	

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	During an interview, on 07/22/22 at 11:33 a.m., the Unit Manager indicated the Director of Nursing and responsible party/guardian were to be notified of changes in condition, to include hospitalizations. The agency nurse which sent Resident 183 out to the hospital had documented she contacted the guardian and DON however the DON had informed the Unit Manager she had not been notified. During an interview, on 07/22/22 at 3:31 p.m., the Director of Nursing indicated she was not made aware, by the agency nurse, Resident 183 went out to the hospital and she should have been notified. An undated facility policy, titled "Physician Notification of Change," provided by the Director of Admissions and Activities on 07/27/22 at 2:01 p.m., indicated "...The following are examples of changes in condition...A decision to transfer or discharge the resident from the nursing home...the Nurse is responsible to notify a family member or responsible party...Please note the...Director of Nursing must be notified of any change in condition...." 3.1-5(a)(2) 3.1-5(a)(4)			
F 0582 SS=D Bldg. 00	483.10(g)(17)(18)(i)-(v) Medicaid/Medicare Coverage/Liability Notice §483.10(g)(17) The facility must-- (i) Inform each Medicaid-eligible resident, in writing, at the time of admission to the nursing facility and when the resident becomes eligible for Medicaid of- (A) The items and services that are included in nursing facility services under the State			

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	plan and for which the resident may not be charged; (B) Those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and (ii) Inform each Medicaid-eligible resident when changes are made to the items and services specified in §483.10(g)(17)(i)(A) and (B) of this section. §483.10(g)(18) The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare/ Medicaid or by the facility's per diem rate. (i) Where changes in coverage are made to items and services covered by Medicare and/or by the Medicaid State plan, the facility must provide notice to residents of the change as soon as is reasonably possible. (ii) Where changes are made to charges for other items and services that the facility offers, the facility must inform the resident in writing at least 60 days prior to implementation of the change. (iii) If a resident dies or is hospitalized or is transferred and does not return to the facility, the facility must refund to the resident, resident representative, or estate, as applicable, any deposit or charges already paid, less the facility's per diem rate, for the days the resident actually resided or reserved or retained a bed in the facility, regardless of any minimum stay or discharge notice requirements. (iv) The facility must refund to the resident or			

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	resident representative any and all refunds due the resident within 30 days from the resident's date of discharge from the facility. (v) The terms of an admission contract by or on behalf of an individual seeking admission to the facility must not conflict with the requirements of these regulations. Based on interview and record review, the facility failed to ensure a resident or the resident's representative was provided timely notification of changes in coverage of Medicare part A services for 1 of 3 residents reviewed for beneficiary notices. (Resident 21) Finding includes: The record for Resident 21 was reviewed on 07/20/22 at 9:00 a.m. Diagnoses included, but were not limited to, influenza, asthma, and atherosclerotic heart disease of native coronary. A SNF beneficiary protection notification document indicated the last covered day of Part A Service was on 5/6/22. The notice of Medicare non-coverage was signed by the resident's husband on 5/5/22. There was no documentation in the electronic medical record to indicate the reason the resident's husband was not notified on time. During an interview, on 07/22/22 at 11:57 a.m., the Minimum Data Set (MDS) Coordinator indicated it was her understanding the beneficiary notice had to be completed within 48 hours of discharge. She indicated she should have documented in the electronic medical record when she notified the husband on the phone, but she did not, and there was no paper record to provide.	F 0582	MHCC Plan of Correction 2022 F- 582 1. The facility failed to ensure resident or resident's guardian was provided timely notification of changes in coverage or Medicare Part A services. 2. All residents have the potential to be affected by this deficient practice. 3. The facility IDT team will meet weekly to ensure that NOMNAC will be distributed within a timely manner and will document appropriately when the resident/family is notified. 4. MDS will monitor Medicare A residents to ensure 100% compliance with the 48 hour timeline.	08/17/2022

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	A facility policy, titled "Instructions for the Notice of Medicare Non-Coverage," dated 2021 and provided by the Social Service Director on 07/22/22 at 3:30 p.m., indicated "...The NOMNC must be delivered at least two calendar days before Medicare covered services end...Confirm the telephone contact by written notice mailed on that same day...." 3.1-4(f)(2) 3.1-4(i)			
F 0656 SS=E Bldg. 00	483.21(b)(1) 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 §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			

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	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.			
	Based on interview and record review, the facility failed to develop a care plan which addressed diabetes and constipation (Resident 3), failed to develop a care plan which addressed anticoagulant use and pain (Resident 31), failed to update the pressure wound care plan (Resident 28) and failed to develop a care plan for code status preferences (Resident 32) for 4 of 13 residents reviewed for care plans. Findings include: 1. The record for Resident 3 was reviewed on 07/20/22. Diagnoses included, but were not limited to, type 2 diabetes mellitus, schizophrenia and hypertension. A physician's order, dated 04/19/21, indicated to check blood sugars daily every morning and at bedtime. A physician's order, dated 06/27/20, indicated to	F 0656	F 656: Comprehensive Care Plans 1. Care plan for Resident 3, 28, 31, 32, were updated to reflect residents medications and documentation on plan of care by August 17, 2022. 2. All residents have the potential to be affected by this deficient practice if comprehensive care plans are not entered at the time of resident diagnosis or change in condition. 1. Weekly Care plan meetings will be instituted to include MDS, Unit Manager, DON and Social Service Director as needed to review existing care plans, new orders, diagnosis, admissions, hospitalizations and change of conditions. 2. Newly admitted residents	08/17/2022

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	give Levemir 14 units at bedtime for type 2 diabetes mellitus. A physician's order, dated 04/08/20, indicated to give Novolog (a medication for diabetes) per the sliding scale (a dose listing of how much insulin to give for the blood sugar result). A physician's order, dated 05/25/20, indicated to give Victoza Solution (a medication for diabetes) 1.8 mg by injection every morning for type 2 diabetes mellitus. A physician's order, dated 10/29/18, indicated to give Senna (a medication for constipation) 8.5-50 milligrams (mg) daily for constipation. There were no care plans found in the record to address diabetes or constipation. 2. The record for Resident 31 was reviewed on 07/20/22 at 3:11 p.m. Diagnoses included, but were not limited to, cerebral infarction due to occlusion or stenosis of a cerebral artery (stroke), pain in an unspecified joint and atrial fibrillation (an irregular heart beat). A physician's order, dated 04/25/19, indicated to give aspirin (a medication used to prevent clotting, pain and treat fever) 81 milligrams (mg) daily for paroxysmal atrial fibrillation. A physician's order, dated 06/25/20, indicated to give Norco (a narcotic pain reliever) 5-325 mg three times a day for pain in an unspecified joint. A physician's order, dated 04/25/19, indicated to give Xarelto (a medication to prevent clot formation in the blood) 20 mg every evening for paroxysmal atrial fibrillation.		will be reviewed by the care plan team within 48 business hours (M-F) by Care Plan team to ensure resident diagnosis or change in condition are addressed and all needs are addressed in a timely manner. These audits will continue as part of the new quality assurance protocol. This audit will be completed by the DON or designee for compliance. These audits will continue as part of the new quality assurance protocol on admissions. Audits will continue until 100% compliance is met and maintained for 3 months. These audits will be tracked and submitted to QAPI for review on monthly basis to ensure compliance.	

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There were no care plans found in the record to address bleeding from taking anticoagulant medications or narcotic medications for pain.

During an interview, on 07/25/22 at 11:38 a.m., the Unit Manager indicated there should have been care plans for pain, diabetes and anticoagulant medications. 3. The record for Resident 28 was reviewed on 07/21/22 at 12:11 p.m. Diagnoses included, but were not limited to, diabetes mellitus, CVA (cerebral vascular accident), and hemiplegia and hemiparesis (weakness or inability to move one side of the body, usually a result of a stroke)

A "Skin Only Evaluation" document, dated 06/23/22, indicated the resident had a new pressure ulcer to his left lower buttocks measuring 1.75 cm (centimeters) in length by 1.5 cm in width and 0.2 cm in depth.

A "Skin Only Evaluation" document, dated 07/20/22, indicated the resident had a pressure ulcer to his left lower buttocks measuring 3.5 cm (centimeters) in length by 2.6 cm in width and 2.3 cm in depth.

A review of the current plan of care indicated a problem of the resident had a potential for a pressure ulcer development related to immobility and the resident has a history of pressure injury with an initiation date of 12/27/16 and revised on 02/07/20. The goal for this problem was "...will have decreased tissue injury through review date." The date of initiation of the goal was "06/24/19" with a revision date of "09/11/22".

Documentation was lacking a current plan of care for the resident's pressure ulcer to the left buttock,

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	to include a measurable goal and interventions targeted to heal the wound. 4. The record for Resident 32 was reviewed on 07/20/22 at 2:00 p.m. Diagnoses included, but were not limited to, pressure ulcer of sacral (tail bone) region, hemiplegia and hemiparesis following a CVA and Diabetes Mellitus. A census document indicated Resident 32 was admitted to the facility on 05/04/22 and expired at the facility on 06/27/22. A physician's order, dated 06/02/22, indicated the resident was receiving Palliative care (specialized medical care to optimize quality of care to those living with a serious illness, often associated with a terminal illness). Documentation was lacking a plan of care for palliative care, code status preference and discharge planning. During an interview, on 07/21/22 at 11:45 a.m., the Social Services Director indicated the resident did not have a care plan which indicated his code status, his discharge plans and for receiving palliative care and he should have had the care plans in place. An undated facility policy, titled "Care Plans," provided by the Social Worker on 07/26/22 at 9:54 a.m., indicated "...Collaboration of the care plan team is used to help analyze data obtained from the resident's diagnosis, staff notation, MDS (Minimum Data Set) and physician's orders to develop individualized care plans specific to each resident...." 3.1-35(a)			

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	3.1-35(d)(1)			
F 0661 SS=D Bldg. 00	483.21(c)(2)(i)-(iv) Discharge Summary §483.21(c)(2) Discharge Summary When the facility anticipates discharge, a resident must have a discharge summary that includes, but is not limited to, the following: (i) A recapitulation of the resident's stay that includes, but is not limited to, diagnoses, course of illness/treatment or therapy, and pertinent lab, radiology, and consultation results. (ii) A final summary of the resident's status to include items in paragraph (b)(1) of §483.20, at the time of the discharge that is available for release to authorized persons and agencies, with the consent of the resident or resident's representative. (iii) Reconciliation of all pre-discharge medications with the resident's post-discharge medications (both prescribed and over-the-counter). (iv) A post-discharge plan of care that is developed with the participation of the resident and, with the resident's consent, the resident representative(s), which will assist the resident to adjust to his or her new living environment. The post-discharge plan of care must indicate where the individual plans to reside, any arrangements that have been made for the resident's follow up care and any post-discharge medical and non-medical services. Based on interview and record review, the facility failed to ensure a discharge summary was complete for 1 of 1 resident reviewed for discharge planning. (Resident 33)	F 0661	F-0661: Discharge Summary 1. Facility physician will be advised of new discharge policy and will receive in service, by the	08/17/2022

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	Finding includes: The record for Resident 33 was reviewed on 7/21/22 at 12:13 p.m. Diagnoses included, but were not limited to, bipolar disorder, Alzheimer's disease and essential (primary) hypertension. There were no records of a recapitulation of the resident stay (a concise summary of the resident's stay and course of treatment in the facility) or a reconciliation of medications (a process of comparing pre-discharge medications to post-discharge medications by creating an accurate list of both prescription and over-the-counter medications which includes the drug name, dosage, frequency, route, and indication for use for the purpose of preventing unintended changes or omissions at transition points in care) in the resident's record. During an interview, on 07/25/22 at 10:21 a.m., the Unit Manager (UM) indicated the facility usually sent the face sheet, discharge summary and a medication list with the resident when discharging home or transferring to another facility. During an interview, on 07/25/22 at 11:30 a.m., the Director of Admissions and Marketing indicated the facility did not have extra documentation on the resident's recapitulation of stay and reconciliation of medications. During an interview, on 07/25/22 at 3:18 p.m., LPN 1 indicated it was an expectation to have a physician's discharge order. The nurse would assess the resident, complete the discharge and transfer summary in electronic health record, print the medication reconciliation list, ensure the resident signs the paperwork, send the information to the receiving facility or with the		Director of Nursing, on discharge summaries. 2. All residents have the potential to be affected by this deficient practice. All discharges will have a completed summary from the discharging physician entered into the medical record within 30 days of discharge. 3. Chart Audit reviews will be done by the DON or designee for correct discharge summary information provided by the physician. The DON or designee will sign off on chart review on post discharge basis during normal business hours (Monday – Friday).	

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	resident going home and keep a copy in the record. A facility policy, titled "Discharge Summary for Physician," undated and provided by the Executive Director on 07/25/22 at 12:15 p.m., indicated "...When the facility anticipates discharge, a resident must have a Discharge Summary that includes... A Recapitulation of the resident's stay... A Final Summary of the resident's status... Reconciliation of all pre-discharge medications...." 3.1-36(a)(1) 3.1-36(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 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 provide adequate supervision for a resident who required the physical assist of one with activities of daily living (ADL's) and implement new fall interventions to help prevent further falls for 1 of 1 resident reviewed for accidents. (Resident 24) Finding includes: During an interview, on 07/19/22 at 11:00 a.m., Resident 24 indicated he had fallen many times	F 0689	MHCC Plan of Correction 2022 F-689 1. The facility failed to document fall interventions for resident #24. 2. All residents have the potential to be affected by this deficient practice. 3. Resident #24 will be assessed by Therapy again for interventions to assist with falls.	08/17/2022

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	because he forgot to lock his breaks on his wheelchair when he finished his shower and went to sit back down in the wheelchair. The resident's quarterly MDS (minimum data set) assessment, dated 05/31/22, indicated the resident required one person physical assist with bathing and transferring. A fall note, dated 06/03/22 at 7:48 p.m., indicated "pt (patient) was attempting to transfer from wheelchair to shower chair and fell." A fall note, dated 06/13/22 at 2:45 p.m., indicated the resident fell in the bathroom off the dining room. The resident stated "I was about to sit in my wheelchair after using the bathroom, when I went to sit down my wheelchair moved." A fall note, dated 06/14/22 at 7:24 p.m., indicated "pt fell while trying to transfer self in shower back to chair." A current care plan, initiated on 01/12/21 and revised on 01/12/21, indicated the resident was at risk for falls related to gait (walking) and balance problems. All interventions in place were initiated on 01/12/21. Documentation was lacking a current plan of care for the resident's actual falls, to include a measurable goal and interventions targeted to help prevent further falls in the future. During an interview, on 07/25/22 at 11:35 a.m., the Executive Director (ED) indicated there was not a current care plan in place which indicated the resident fell on 6/3/22, 6/13/22 and on 6/14/22 and there were not any new interventions documented for each of the falls and there should have been.		4. An IDT meeting will take place weekly to review falls and fall interventions. ED will audit monthly for three months to ensure compliance with fall interventions.	

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	A current policy, titled "Fall Assessment Policy," dated as revised 2020 and provided by the Social Service Director on 07/26/22 at 10:00 a.m., indicated "...Policy and Procedure Implementation...interventions will be address on the CNA Assignment Sheet and resident's care plan...." 3.1-45(a)(2)			
F 0700 SS=D Bldg. 00	483.25(n)(1)-(4) Bedrails §483.25(n) Bed Rails. The facility must attempt to use appropriate alternatives prior to installing a side or bed rail. If a bed or side rail is used, the facility must ensure correct installation, use, and maintenance of bed rails, including but not limited to the following elements. §483.25(n)(1) Assess the resident for risk of entrapment from bed rails prior to installation. §483.25(n)(2) Review the risks and benefits of bed rails with the resident or resident representative and obtain informed consent prior to installation. §483.25(n)(3) Ensure that the bed's dimensions are appropriate for the resident's size and weight. §483.25(n)(4) Follow the manufacturers' recommendations and specifications for installing and maintaining bed rails. Based on observation, interview and record review, the facility failed to obtain an order, complete an assessment and to obtain a consent for the use of bed rails for 1 of 1 resident reviewed	F 0700	MHCC Plan of Correction 2022 F-700 Side Rails 1. The facility failed to obtain	08/17/2022

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	for bed rails and accidents. (Resident 13) Finding includes: During an observation, on 07/20/22 at 8:47 a.m., Resident 13 was observed resting in bed with the top side rails up on both sides of her bed. During an observation, on 07/20/22 at 2:28 p.m., Resident 13 was observed in a low bed, her head of the bed was elevated and she had upper side rails up on both sides of her bed. During a medication administration observation, on 07/21/22 at 9:47 a.m., Resident 13 was observed in bed with the top side rails up on both sides of her bed. During an observation, on 07/21/22 at 1:47 p.m., Resident 13 was observed resting in bed with both upper side rails raised. During an observation, on 07/22/22 at 10:08 a.m., Resident 13 was observed in bed with both upper side rails raised. The record for Resident 13 was reviewed on 07/20/22 at 2:25 p.m. Diagnoses included, but were not limited to, seizures, muscle weakness and delusional disorder. There was no order for side rails found in the record. There was no consent for the use of side rails found in the record. There was no care plan for the use of side rails found in the record.		an order, complete an assessment and obtain a consent for the use of bed rails for resident #13. 2. All residents have the potential to be affected by this deficient practice. 3. The facilities MD will order an assessment to be completed and issue an order for the side rails. Nursing will assess the resident for need for side rails and will complete a comprehensive person centered care plan for the side rails. 4. The facility will complete an audit of residents with side rails and ensure there is an assessment, order, consent and care plan in place.	

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	There was no assessment for the use of side rails found in the record. During an interview, on 07/26/22 at 9:57 a.m., the Social Services Worker indicated the facility did not have an order, assessment or consent for Resident 13 to use bed rails. During the exit conference, on 07/26/22, the Executive Director indicated there should have been an order for side rails and he thought there was one. A facility policy, titled "McGivney Health Care Center Side Rail Protocol," dated as reviewed on 07/07/2017 and provided by the Social Worker on 07/26/22 at 9:54 a.m., indicated "...Upon admission/readmission, the Charge Nurse will complete the Side Rail Assessment form...A physician's order will be obtained based on the resident's assessment and needs...Re-assessment will occur every quarter...or when there is a significant change...." 3.1-45(a)(2)			
F 0758 SS=E Bldg. 00	483.45(c)(3)(e)(1)-(5) Free from Unnec Psychotropic Meds/PRN Use §483.45(e) Psychotropic Drugs. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic			

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	Based on a comprehensive assessment of a resident, the facility must ensure that--- §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and §483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order. §483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication. Based on interview and record review, the facility failed to complete an AIMS (abnormal involuntary movement scale) assessment (used to measure abnormal involuntary movements after taking	F 0758	MHCC Plan of Correction 2022 F-758- AIMS 1. The facility failed to	08/17/2022

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	anti-psychotic medications for a prolonged period of time) in a timely manner for 4 of 5 residents reviewed for unnecessary medications. (Resident 24, 3, 15 and 31) Findings include: 1. The record for Resident 24 was reviewed on 07/20/22 at 3:51 p.m. Diagnoses included, but were not limited to, dementia, traumatic brain injury and delusional disorder. A current physician's order, dated 06/20/22, indicated the resident was receiving olanzapine (a medication used to treat psychotic illness) 1.5 milligrams once daily. A current care plan, dated as revised on 07/21/22, indicated the resident was receiving olanzapine for the treatment of behaviors related to delusional disorder. Interventions included, but were not limited to, monitor for adverse reactions of medication including tardive dyskinesia (involuntary movement brought on by the use of an antipsychotic medications (olanzapine). During an interview, on 07/25/22 at 11:30 a.m., the Unit Manager indicated she could not provide an AIMS assessment for Resident 24 and he should have had one completed every six months. 2. The record for Resident 3 was reviewed on 07/20/22. Diagnoses included, but were not limited to, type 2 diabetes mellitus, schizophrenia and hypertension. A physician's order, dated 10/29/18, indicated to give Benztropine Mesylate (a medication used to treat involuntary movements due to the side effects of certain psychiatric drugs) 0.5 milligrams (mg) twice a day for schizophrenia.		complete an AIMS assessment for residents #3, #15, #24 and #31. 2. All residents have the potential to be affected by this deficient practice. 3. An AIMS will be completed for all MHCC residents who are currently taking psychotropic medications to monitor for side effects quarterly. 4. AIMS assessments are implemented through Point Click Care quarterly.	

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A physician's order, dated 02/15/21, indicated to give Invega Sustenna 78 milligrams/0.5 milliliters (a medication for schizophrenia) via injection once a month for schizophrenia.

A care plan, initiated on 11/03/18, indicated Resident 3 used a psychotropic medication for a diagnosis of schizophrenia and to monitor/document/report any adverse reactions of the psychotropic medication to include EPS (Extrapyramidal side effects-drug induced movement disorders).

The last AIMS assessment completed on Resident 3 was on 03/10/2021.

3. The record for Resident 15 was reviewed on 07/20/22 at 12:23 p.m. Diagnoses included, but were not limited to, schizoaffective disorder, major depressive disorder and encephalopathy (a disease in which the functioning of the brain was affected by some agent or condition).

A physician's order, dated 03/19/18, indicated to give benztropine mesylate 1 mg twice a day for EPS.

A physician's order, dated 07/24/19, indicated to give Risperdal Consta Suspension 12.5 mg intramuscularly one time a day every 2 weeks on Saturday for schizoaffective disorder, depressive type.

A physician's order, dated 03/16/21, indicated to give Risperdal Consta Suspension 12.5 mg intramuscularly one time a day every 2 weeks on Thursday for schizoaffective disorder, depressive type.

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	A care plan, initiated on 11/06/16, indicated Resident 15 received Benztropine Mesylate related to a diagnosis of EPS. The resident would have no evidence of EPS through the review period and to monitor/document for side effects. A care plan, initiated on 11/06/16, indicated Resident 15 received psychotropic medications for a diagnosis of schizoaffective disorder and to observe/document/report any adverse reactions of psychotropic medications to include EPS. The last AIMS assessment was completed on 11/23/21. 4. The record for Resident 31 was reviewed on 07/20/22 at 3:11 p.m. Diagnoses included, but were not limited to, vascular dementia with behavioral disturbance, major depressive disorder and mild cognitive impairment. A physician's order, dated 02/11/20, indicated to give Haloperidol (an antipsychotic medication) 0.5 mg daily at bedtime. A care plan, initiated on 07/29/21, indicated Resident 31 was on Haloperidol and to monitor/document/report any adverse reactions of the psychotropic medication to include EPS. The last AIMS assessment was completed on 01/11/21. During an interview, on 07/22/22 at 11:00 a.m., the Social Services Worker indicated nursing was responsible for completing an AIMS assessment. During an interview, on 07/25/22 at 11:38 a.m., the Unit Manager indicated the Director of Nursing was to complete AIMS assessments.			

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	A facility policy, titled "McGivney Health Care Center AIMS (Abnormal Involuntary Movement Scale) Procedure," dated as effective 08/2017 and provided by the Unit Manager on 07/25/2022 at 10:49 a.m., indicated "...The AIMS shall be completed within 14 days of initiation of psychotropic medication...and every 6 months after...." 3.1-48(a)(3)			
F 0812 SS=D 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 ensure a cook wore gloves while preparing pureed food during the	F 0812	MHCC Plan of Correction 2022 F- 812	08/10/2022

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	155855	A. BUILDING 00 B. WING	07/26/2022

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

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	lunch meal preparation for 1 of 1 cook observed pureeing food. (Cook 1) Finding includes: During an observation, on 07/20/22 at 11:49 a.m., with the Dietary Manager present, Cook 1 was observed to puree chicken Alfredo without wearing gloves. She measured out the entree, spooned it into the food processor and then turned on the machine to grind down the food to a paste or to a thick liquid texture. She stopped the machine to check on the process and when she reassembled the machine she touched the inside where the food was being ground up with her ungloved hand. During an interview, at that time, the Dietary Manager indicated she should have worn gloves whenever preparing food. A current policy, titled "Guidelines for Proper Glove Use in Food Services," undated and provided by the Director of Admissions and Marketing on 07/27/22 at 1:45 p.m., indicated "...McGivney Health Care Center recognizes contamination of food by the hands of food handlers is an important cause of foodborne illness outbreaks...gloves...provide an effective barrier between the hands of food handlers and the foods they handle...." 3.1-21(i)(3)		1. The facility failed to comply with guidelines for proper glove use in food services. 2. All residents have the potential to be affected by this deficient practice. 3. Dietary staff was in serviced and trained on proper glove use in food service on 8/10/22 by Dietary Consultant. 4. Dietary consultant and Dietary will educate new dietary staff regarding proper glove use upon orientation.	
F 0883 SS=E 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			

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	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 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			

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	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 offer the Influenza vaccine for 2022 and the Pneumonia vaccination for 4 of 5 residents reviewed for Influenza and Pneumonia vaccinations. (Resident's 16, 18, 27, 28) Findings include: 1. Resident 16's most current consent to receive the influenza vaccine was signed by his POA on 03/09/21. Documentation was lacking a current consent or declination to administer the influenza vaccine for 2022 and any consent or declination the pneumonia vaccine was ever offered. 2. Resident 18's most current declination to receive the influenza vaccine was signed by her POA on 04/30/21. Documentation was lacking a current consent or declination to administer the influenza vaccine for 2022. 3. Resident 27's most current consent to receive the influenza vaccine was signed by his POA on 02/09/21. Documentation was lacking a current consent or declination to administer the influenza vaccine for 2022. 4. Resident 28's most current consent to receive	F 0883	MHCC Plan of Correction 2022 F- 883 1. The facility failed put the influenza vaccine documentation under the immunization section in Point Click Care. 2. All residents have the potential to be affected by this deficient practice. 3. The facility will provide influenza and pneumococcal vaccines to all residents that want them by October 1, 2022. 4. The documentation from the clinics will be entered into Point Click Care within 30 days of administering the vaccines.	08/17/2022

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	the influenza vaccine was signed by himself on 03/05/21. Documentation was lacking a current consent or declination to administer the influenza vaccine for 2022. During an interview, on 07/25/22 at 2:09 p.m., the Unit Manager indicated influenza and pneumonia vaccinations should be offered yearly and if a resident refused they should be educated on risk versus benefits and have a consent/refusal signed and made part of the resident's medical record. A current policy, titled "Influenza and Pneumococcal Immunizations," dated 2016 and provided by the Director of Admissions and Marketing on 7/19/22 at 12:45 a.m., indicated "...Each resident is offered an influenza immunization October 1 through March 31 annually...The resident's medical record includes documentation that indicates...That the resident either received the influenza immunization or did not...Each resident is offered a pneumococcal immunization...The resident's medical record includes documentation that indicates...That the resident either received the pneumococcal immunization or did not...." 3.1-18(b)(5)			
F 0886 SS=F Bldg. 00	483.80 (h)(1)-(6) COVID-19 Testing-Residents & Staff §483.80 (h) COVID-19 Testing. The LTC facility must test residents and facility staff, including individuals providing services under arrangement and volunteers, for COVID-19. At a minimum, for all residents and facility staff, including individuals providing services under			

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	arrangement and volunteers, the LTC facility must: §483.80 (h)((1) Conduct testing based on parameters set forth by the Secretary, including but not limited to: (i) Testing frequency; (ii) The identification of any individual specified in this paragraph diagnosed with COVID-19 in the facility; (iii) The identification of any individual specified in this paragraph with symptoms consistent with COVID-19 or with known or suspected exposure to COVID-19; (iv) The criteria for conducting testing of asymptomatic individuals specified in this paragraph, such as the positivity rate of COVID-19 in a county; (v) The response time for test results; and (vi) Other factors specified by the Secretary that help identify and prevent the transmission of COVID-19. §483.80 (h)((2) Conduct testing in a manner that is consistent with current standards of practice for conducting COVID-19 tests; §483.80 (h)((3) For each instance of testing: (i) Document that testing was completed and the results of each staff test; and (ii) Document in the resident records that testing was offered, completed (as appropriate to the resident's testing status), and the results of each test. §483.80 (h)((4) Upon the identification of an individual specified in this paragraph with			

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	symptoms consistent with COVID-19, or who tests positive for COVID-19, take actions to prevent the transmission of COVID-19. §483.80 (h)((5) Have procedures for addressing residents and staff, including individuals providing services under arrangement and volunteers, who refuse testing or are unable to be tested. §483.80 (h)((6) When necessary, such as in emergencies due to testing supply shortages, contact state and local health departments to assist in testing efforts, such as obtaining testing supplies or processing test results.			
	Based on interview and record review, the facility failed to test 10 exempt employees for COVID-19 two times weekly while the county transmission rate was high. This deficient practice had the potential to affect 31 of 31 residents who reside at the facility. Finding includes: During an interview, on 07/22/22 at 10:30 a.m., the Unit Manager indicated she was not vaccinated for COVID-19, she had an approved non-medical exemption and was tested for COVID-19 weekly. During an interview, on 07/26/22 at 1:00 p.m., the Executive Director indicated exempted staff were tested for COVID-19 one time weekly, he was also aware the community transmission level was high and the exempted unvaccinated staff should have been tested twice weekly.	F 0886	MHCC Plan of Correction 2022 F- 886 1. The facility failed to administer COVID-19 testing for 10 exempt employees twice a week per the CDC guidelines. 2. All residents have the potential to be affected by this deficient practice. 3. The facility will provide COVID-19 testing per the CDC guidelines. 4. ED will audit COVID-19 testing for 100% compliance for three months.	08/17/2022

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	A current policy, titled "COVID-19 Vaccination Requirements," undated and provided by the Director of Admissions and Marketing on 07/20/22 at 9:47 a.m., indicated "...It is the policy of McGivney Heath Care Center to provide a safe, sanitary and comfortable environment as well as provide guidelines to prevent the development and transmission of infection....McGivney Health Care Center will also comply with Covid-19 testing requirements that are required by any federal, state, or local governments, or accrediting bodies...." 3.1-18(b)			
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) This deficient practice had the potential to effect 2 of 2 residents who resided in the room (Room 1). Findings include: During the entrance conference, on 07/19/22 at 10:00 a.m., the Maintenance Director indicated there had been no physical changes to the room which had a previous room waiver since the last survey on 06/11/21. He indicated Room 1 had two beds, two residents, and currently had a waiver. During the initial facility observation, on 07/19/22 at 11:15 a.m., Room 1 was found to have 2 beds.	F 0912	F912 Facility Square Feet per Resident Room 1. It is policy of the facility to provide at least 80 square feet per resident in mulitple resident rooms, and at least 100 square feet in single resident rooms. 2. Affected residents: Residents in Room 1 were found not to meet the requirement, however a waiver was in effect for the room. 3. Quality Assurance: A letter has been sent to ISDH to request a room waiver. Room 1 has privacy, comfort, and adequate space to provide nursing care as evidenced by Room 1 being	08/10/2022

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	During an observation of Room 1, on 07/21/22 at 2:00 p.m., it was noted two residents was occupying the room. A review of the facility measurement 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. During an interview, on 07/25/22 at 12:37 p.m., the Administrator indicated two residents were utilizing Room 1 and the bed inventory had two beds listed for Room 1 and a room size waiver had been requested in the past and granted. He indicated the room size was supposed to be 80 square feet per resident, 120 square feet per 2 residents. 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 received on 7/18/2016 at 10:00 a.m., from the Administrator, 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)		occupied by two residents who ambulate independently. Room 1 is equipped with privacy curtains, comfortable bed environment, and adequate space. The method of monitoring any negative outcome due to size of room has been negated through placement of only one or two residents in respective rooms. The facility will continue to monitor for any potential negative outcome due to room size and variance in an ongoing capacity. Should a negative outcome arise, this will be addressed immediately in accordance with any potential issue.	