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	10/02/2024

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 25, 26, 27, 30 and October 1 and 2, 2024. Facility number: 000545 Provider number: 155855 AIM number: 100267350 Census Bed Type: SNF/NF: 33 Total: 33 Census Payor Type: Medicare: 32 Medicaid: 1 Total: 33 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review was completed on October 4, 2024.	F 0000		
F 0656 SS=D Bldg. 00	483.21(b)(1)(3) Develop/Implement Comprehensive Care Plan Based on interview and record review, the facility failed to develop a comprehensive care plan which addressed constipation, insomnia, hyperlipidemia, and pain for 2 of 2 residents reviewed for Based on interview and record review, the facility failed to develop a comprehensive care plan which addressed constipation, insomnia, hyperlipidemia, and pain for 2 of 2 residents reviewed for comprehensive care plans. (Resident 11 and 26)	F 0656	F 656: Comprehensive Care Plans 1 Care plan for Resident 11 and 26, were updated to reflect resident's medications and diagnosis. 2 All residents have the potential to be affected by this	10/24/2024

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Randall Shera	Executive Director	10/21/2024

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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	Findings include: 1. During an interview, on 9/25/24 at 10:59 a.m., Resident 11 indicated he was often constipated. The clinical record for Resident 11 was reviewed on 9/27/24 at 11:01 a.m. The diagnoses included, but were not limited to, muscle weakness, abnormal weight loss, and chronic idiopathic constipation. A physician's order, initiated on 2/20/23, indicated to give Linzess Oral Capsule (a medication for constipation) 145 micrograms (mcg) once a day related to chronic idiopathic constipation. A physician's order, initiated on 3/2/22, indicated to give Miralax Powder (a medication for constipation) 17 grams/scoop in the morning for constipation. There was no care plan found in the record to indicate the resident was prone to constipation and the use of Linzess or Miralax. During an interview, on 10/2/24 at 10:08 a.m., the Minimum Data Set (MDS) Nurse indicated she did not believe the facility had a policy addressing what needed to be care planned. During an interview, on 10/2/24 at 11:00 a.m., the MDS Nurse indicated the resident should have had a care plan addressing constipation. 2. The clinical record for Resident 26 was reviewed on 9/26/24 at 2:25 p.m. The diagnoses included, but were not limited to, hyperlipidemia, pain in an unspecified joint, and insomnia. A physician's order, initiated on 8/27/21, indicated		deficient practice if comprehensive care plans are not entered at the time of resident diagnosis or change in condition. 3 Quarterly Care plan meetings will occur and 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. Weekly clinical meetings will occur to review any new changes in medication, dosage, diagnoses or change in condition. 4 Social Services and Nursing will review care plans for six months to ensure 100% accuracy within care plans.	

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	to give Lipitor (a cholesterol medication) 10 milligrams daily at bedtime for mixed hyperlipidemia (elevated levels of fat in the blood). A physician's order, initiated on 4/22/22, indicated to give Melatonin (a supplement to help with sleep disorders) six (6) milligrams at bedtime for insomnia. A physician's order, initiated on 3/22/24, indicated to give tramadol (a pain reliever) 100 milligrams twice a day for joint pain. There were no care plans addressing the use of Lipitor for hyperlipidemia, Melatonin for insomnia or tramadol for pain found in the record. During an interview, on 10/2/24 at 10:07 a.m., the MDS Nurse indicated the resident should have had a care plan addressing mixed hyperlipidemia, difficulty sleeping, and pain. A current facility policy, titled "Care Plans," dated as last reviewed in 2024 and received from the Executive Director on 10/2/24 at 10:32 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) 3.1-35(b)(1)			
F 0757 SS=D Bldg. 00	483.45(d)(1)-(6) Drug Regimen is Free from Unnecessary Drugs Based on interview and record review, the facility	F 0757	MHCC Plan of Correction 2024	10/24/2024

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	failed to obtain laboratory results for the monitoring and effectiveness of a cholesterol medication for 1 of 5 residents reviewed for unnecessary medications. (Resident 26) Finding includes: The clinical record for Resident 26 was reviewed on 9/26/24 at 2:25 p.m. The diagnoses included, but were not limited to, pain in an unspecified joint, insomnia, and mixed hyperlipidemia. A physician's order, initiated on 8/27/21, indicated to give Lipitor (a medication for high cholesterol) 10 milligrams daily at bedtime for mixed hyperlipidemia. A laboratory result, dated 2/11/22, indicated the resident had a high triglyceride level of 188. There were no other laboratory results in the record to indicate a lipid profile (a blood test to monitor the lipid levels in the blood) had been monitored after 2/11/22. There were no entries in the record to indicate laboratory orders had been received and/or were pending. During an interview, on 10/2/24 at 10:07 a.m., the Minimum Data Set (MDS) Nurse indicated the facility did not have a policy addressing monitoring laboratory results for medications and there were no current laboratory results to show monitoring of the cholesterol levels. During a telephone interview, on 10/2/24 at 10:48 a.m., Nurse Practitioner 2 indicated cholesterol labs should be checked at least annually.		F-757 1 The facility failed to obtain laboratory results for the monitoring and effectiveness of a cholesterol medication for 1 of 5 resident reviewed for unnecessary medications. 2 All residents have the potential to be affected by this deficient practice. 3 Medical Director order annual lab orders for all 33 residents and as needed. 4 Quarterly Audits will be preformed during care plan meetings with 100% accuracy for 6 months.	

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	The facility was not able to provide a policy addressing the monitoring of the medication. 3.1-48(a)(3)			
F 0758 SS=D Bldg. 00	483.45(c)(3)(e)(1)-(5) Free from Unnec Psychotropic Meds/PRN Use Based on interview and record review, the facility failed to monitor and document a resident's delusions related to the use of an antipsychotic medication for 1 of 5 residents reviewed for unnecessary medications. (Resident 28) Finding includes: The clinical record for Resident 28 was reviewed on 10/1/24 at 9:21 a.m. The diagnoses included, but were not limited to, unspecified dementia, psychotic disorder with delusions, alcohol abuse, and hyperlipidemia. A physician's order, with a start date of 4/5/24, indicated to give Zyprexa (an antipsychotic medication) 7.5 milligrams (mg) by mouth at bedtime for a psychotic disorder with delusions. A care plan, with a revision date of 1/28/21, indicated the resident displayed at times delusions he believed he was incarcerated and he planned to discharge. A care plan, with a revision date of 4/12/24, indicated the resident used the psychotropic medication Zyprexa related to psychosis with delusions. During an interview, on 10/1/24 at 9:58 a.m., the Director of Nursing (DON) indicated Resident 28 did have delusions. Behaviors should be	F 0758	MHCC Plan of Correction 2024 F-758 1 The facility failedto monitor and document a resident's delusions related to the use of an antipsychotic medication for 1 of 5 residents reviewed for unnecessary medications 2 All residents have the potential to be affected by this deficient practice. 3 McGivney updated policy to include nursing as primary responsible for charting on behaviors. In-service on educating staff on documentation on behaviors will be on October 24, 2024. 4 Weekly Audits on behavior notes will be done by IDT Team. IDT Team will audit for 6 months with 100% accuracy.	10/24/2024

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	documented in the progress notes in a behavior note. During an interview, on 10/1/24 at 2:18 p.m., Licensed Practical Nurse (LPN) 3 indicated Resident 28 did have delusions. They document behaviors in the behavior notes. The resident thought someone was coming to pick him up from the facility when nobody was coming to pick him up. The resident would want to wear jeans and if staff would put anything else but jeans on him, he would say it was not the law. During an interview, on 10/1/24 at 2:40 p.m., the Minimum Data Set (MDS) Coordinator indicated Resident 28 did have delusions. She did not see anything in the notes about him having any delusions, During an interview, on 10/1/24 at 2:40 p.m., the DON indicated Resident 28 did have delusions. She did not see anything in the notes about him having any delusions. A Point of Care (POC) response history for the resident's behavior monitoring and interventions log indicated no delusions were marked from 5/30/24 to 10/2/24. A current facility policy, titled "Use of Antipsychotic Medications/Gradual Dose Reductions," undated and received from the Executive Director on 10/2/24 at 10:30 a.m., indicated "...Residents who have not used antipsychotic medications are not to be given these medications unless antipsychotic medication therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record...."			

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	A current facility policy, titled "Behavior Tracking," with a revision date of 2024 and received from the Executive Director on 10/2/24 at 10:50 a.m., indicated "...Behavior tracking is in the Point of Care (POC). Certified Nursing Assistants (CNAs) will track behavior interventions through POC. All staff observations regarding behaviors will be reported to Nursing and/or Social Services. Nursing and/or Social Services will put in a behavior progress note...." 3.1-48(a)(3) 3.1-48(a)(4) 3.1-48(a)(5) 3.1-48(b)(1)			
F 0812 SS=D Bldg. 00	483.60(i)(1)(2) Food Procurement,Store/Prepare/Serve-Sanitary Based on observation and interview, the facility failed to ensure food was properly stored in a kitchen refrigerator for 1 of 1 kitchen reviewed for food service safety. (the refrigerator) Finding includes: During an observation, on 9/27/24 at 11:02 a.m., there was thawing meat stored above a gallon of milk, next to yogurt and a grocery sack of green bell peppers which belonged to a resident and were unlabeled in a kitchen refrigerator. During an interview, on 9/27/24 at 11:09 a.m., the Kitchen Manager indicated the milk should be stored on the top rack and not under the thawing meat. They should not store residents' food in the kitchen refrigerator. They have a refrigerator for storing residents' food downstairs in storage. A current policy, titled "McGivney Health Care	F 0812	MHCC Plan of Correction 2024 F-812 1.="" span="">The Facility Failed to ensure food was properly stored in a kitchen refrigerator for 1 of 1 kitchen reviewed for food service safety. 2.All residents have the potential to be affected by this deficient practice. 3.McGivney will be educated all staff on October 24, 2024 for food storage policy. 4. Daily Audits will be conducted by Dietary Manager for 3 months with 100% accuracy.	10/24/2024

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	Center Food and Nutrition Policy," dated as last revised 3/1/17 and received from the Executive Director on 10/2/24 at 10:30 a.m., indicated "...Uncooked and raw animal products and fish will be stored separately in drip-proof containers and below fruits, vegetables and other ready-to-eat foods...All foods belonging to residents must be labeled with the resident's name, the item and the "use by date"...." 3.1-21(i)(3)			
F 0912 SS=D Bldg. 00	483.90(e)(1)(ii) Bedrooms Measure at Least 80 Sq Ft/Resident Based on observation, interview and record review, the facility failed to provide at least 80 square feet per resident in 1 of 18 rooms reviewed for living space. (Room 1) Finding includes: During the entrance conference, on 9/25/24 at 10:12 a.m., the Director of Nursing indicated Room 1 continued to have a room size waiver. During an observation of Room 1 with Maintenance Staff 4, on 9/25/24 at 9:44 a.m., the room was found to contain two beds and two free standing wardrobes which were used for clothing and storage of personal items belonging to the two occupants of the room. A review of the facility measurement indicated Room 1 was 153.83 square feet and according to Life Safety code the double occupancy of the room allowed 76.9 square feet of living space per resident. During an interview, on 9/30/24 at 2:34 p.m., Resident 29 indicated he liked his room and felt he had enough space for himself and his roommate.	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 multiple 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 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	10/24/2024

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	During an interview, on 9/30/24 at 2:49 p.m., Resident 21 indicated he had no concerns with his room and felt he had enough space for himself and his personal belongings. During an interview, on 10/2/24 at 11:34 a.m., the Executive Director indicated Room 1 was occupied by two residents and should have 80 square feet of living space per resident. A "Bed Inventory" form, received on 10/2/24, indicated Room 1 was a Title 18/19 SNF/NF (Medicare and Medicaid) room and was certified for two resident beds. 3.1-19(l)(2)(A)		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.	