STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155855	A. BUILDING **01** B. WING _____	R **12/17/2024**

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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
{E 000}	Initial Comments	{E 000}		
{K 000}	INITIAL COMMENTS A Post Survey Revisit (PSR) to the Post Survey Revisit conducted on 11/21/24 to the Life Safety Code Recertification and State Licensure Survey conducted on 10/22/24 was conducted by the Indiana Department of Health in accordance with 42 CFR 483.90(a). Survey Date: 12/17/24 Facility Number: 000545 Provider Number: 155855 AIM Number: 100267350 At this PSR Life Safety Code survey, McGivney Health Care Center was found in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.90(a), Life Safety from Fire, and the 2012 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19, Existing Health Care Occupancies and 410 IAC 16.2. This one-story facility with a basement was determined to be of Type V (111) construction and was fully sprinklered. The facility has a fire alarm system with smoke detection in the corridors, all areas open to the corridor and hard-wired smoke detectors in all resident sleeping rooms. The basement was included in this survey. The basement, without 2 hour separation, has apartment residences and at the time of this survey at least 3 of the apartments were occupied by the public. The facility has a capacity of 37 and had a census of 32 at the time of this PSR	{K 000}		

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155855	A. BUILDING **01** B. WING _____	R **12/17/2024**

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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
{K 000}	Continued From page 1 survey. All areas where residents have customary access were sprinklered. All areas providing facility services were sprinklered except for a detached storage building which was not sprinklered. Quality Review completed on 12/18/24	{K 000}		