STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155855	A. BUILDING _____ B. WING _____	**06/10/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
MCGIVNEY HEALTH CARE CENTER	**2907 EAST 136TH ST CARMEL, IN 46033**

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0580 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to notify the physician of a resident fall (Resident B) which resulted in the resident falling on top of another resident (Resident C) for 2 of 5 residents reviewed for accidents. Findings include: 1. The record for Resident B was reviewed on 06/10/20 at 11:04 a.m. [DIAGNOSES REDACTED]. A statement, typed by and provided by, the Executive Director on 06/10/20 at 12:50 p.m., indicated Resident B .fell into the bed A nursing note for Resident B, dated 05/04/20 at 12:59 a.m., indicated .When asked why he (Resident B) was on top of her (Resident C), stated I fell ! There was no documentation which indicated the physician had been notified of the fall in the resident's record. 2. The record for Resident C was reviewed on 06/11/20 at 11:30 a.m. [DIAGNOSES REDACTED]. There was no documentation which indicated the physician was notified of the resident having had another resident fall on top of her. During an interview, on 06/10/20 at 4:30 p.m., the Director of Nursing (DON) indicated there was no further information to indicate the physician was notified Resident B fell into the bed of Resident C and landed on top of her. An undated facility policy, titled Physician Notification on Change in Condition, provided by the DON on 06/10/20 at 4:01 p.m., indicated .When there is a change of condition, the Nurse is responsible to .notify the physician .examples of changes in condition .Fall with or without injury .the Physician .must be notified .immediately An undated facility document, titled Nursing Fall Procedure Check List, provided by the DON on 06/10/20 at 4:01 p.m., indicated .call the doctor This Federal tag relates to Complaint IN 730. 3.1-5(a)(1)
F 0684 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Provide appropriate treatment and care according to orders, resident's preferences and goals.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure nursing and social service related assessments were completed for 2 of 5 residents reviewed for accidents. (Resident B and C) Findings include: 1. The record for Resident B was reviewed on 06/10/20 at 11:04 a.m. [DIAGNOSES REDACTED]. A nursing note for Resident B, dated 05/04/20 at 12:59 a.m., indicated .When asked why he (Resident B) was on top of her (Resident C), stated I fell ! A statement, typed by and provided by, the Executive Director on 06/10/20 at 12:50 p.m., indicated Resident B .fell into the bed There were no neurological checks, physical assessments for injury or Morse fall scale assessment (a tool used to determine a resident's risk for falling) documented in the resident's record after the resident fell into another resident's bed and landed on top of her. During an interview, on 06/10/20 at 4:30 p.m., the Director of Nursing (DON) indicated there was no further information, in Resident B's chart, to indicate additional information, such as assessments for neurological changes or injury, were collected after the fall. 2. The record for Resident C was reviewed on 06/11/20 at 11:30 a.m. [DIAGNOSES REDACTED]. A Minimum Data Set (MDS) assessment, dated 03/14/20, indicated the resident's cognition was severely impaired, her speech was unclear and she was sometimes understood. There were no notes or assessments, in Resident C's chart, to indicate the resident had been assessed for physical or psychosocial injury related to having another resident fall on top of her while she was in her bed. During an interview, on 06/10/20 at 3:24 p.m., the DON indicated an unwitnessed fall required at a minimum, an assessment of neurological checks and injury assessment. Falling onto another resident would require and assessment of both residents for injuries. A facility policy, titled Fall Assessment Policy, dated as revised in 2020, provided by the DON on 06/10/20 at 4:01 p.m., indicated .Should a resident fall, the licensed personnel will follow the Fall Procedure Check list . An undated facility document, titled Nursing Fall Procedure Check List, provided by the DON on 06/10/20 at 4:01 p.m., indicated .Physical Assessment .call the doctor SBAR (SBAR stands for Situation, Background, Assessment and Recommendation and is used to gather information for reporting to the physician) Morse Fall Scale .Neuro Check (an assessment to measure for changes in neuro activity) This Federal tag relates to Complaint IN 730. 3.1-37(a)
F 0880 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Many	**Provide and implement an infection prevention and control program.** Based on observation, interview and record review, the facility failed to ensure staff handled clean linen in a sanitary manner (Employee 1). This deficient practice had the potential to effect 34 of 34 residents who resided in the facility. Finding includes: During a random observation, on 06/10/20 at 9:40 a.m., Employee 1 was observed folding a clean sheet up against her uniform. She placed the folded sheet onto a pile of other clean linen. She then proceeded to fold a linen incontinence pad, placing it against the front of her body, making contact with her uniform. During an interview, immediately following the observation, Employee 1 indicated she did not know (to keep the clean linen from touching her clothing) and she was new. During an interview, on 06/10/20 at 3:24 p.m., the Director of Nursing (DON) indicated clean linens were not to make contact with staff clothing. A facility policy, titled Linen Handling and Storage, dated as effective 06/13/19 and provided by the Executive Director on 06/10/20 at 11:11 a.m., indicated .all linen is handled, stored, transported and processed in a manner that will prevent contamination This Federal tag relates to Complaint IN 730. 3.1-19(g)

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

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days 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 disclosable 14 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.