STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155131	A. BUILDING 00 B. WING	08/23/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
MUNSTER MED-INN	7935 CALUMET AVE MUNSTER, IN 46321

(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. This visit included the Investigation of Complaint IN00358590. Complaint IN00358590 - Substantiated. Federal/State deficiencies related to the allegations are cited at F677. Survey dates: August 16, 17, 18, 19, 20, and 23, 2021 Facility number: 000056 Provider number: 155131 AIM number: 100289450 Census Bed Type: SNF: 16 SNF/NF: 164 Total: 180 Census Payor Type: Medicare: 41 Medicaid: 100 Other: 39 Total: 180 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on 8/31/21.	F 0000	Please accept the evidence submitted for approval and a desk review	
F 0558 SS=D Bldg. 00	483.10(e)(3) Reasonable Accommodations Needs/Preferences §483.10(e)(3) The right to reside and receive services in the facility with reasonable accommodation of resident needs and			

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

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	preferences except when to do so would endanger the health or safety of the resident or other residents. Based on observation, record review and interview, the facility failed to accommodate the needs of a dependent resident related to the call light being out of reach for 1 of 35 residents observed for call lights. (Resident 143) Finding includes: On 8/17/21 at 3:12 p.m., Resident 143 was observed awake in bed. The call light was on the floor next to the resident's bed. On 8/18/21 at 8:49 a.m., the resident was sleeping in her bed, the call light light was observed on the floor. At 2:00 p.m., CNA 1 was observed in the room with the resident providing care. When the CNA exited the room at 2:06 p.m., the call light was still on the floor. The resident's record was reviewed on 8/17/21 at 2:40 p.m. Diagnoses included, but were not limited to, iron deficiency anemia, weakness and diabetes mellitus. The Quarterly Minimum Data Set (MDS) assessment, dated 6/1/21, indicated the resident had moderate cognitive impairment and needed extensive two person assistance for bed mobility. Interview with the resident on 8/17/21 at 3:12 p.m., indicated she didn't know where her call light was, but she was able to use it. Interview with Nurse Consultant 1, on 8/18/21 at 2:11 p.m., indicated the call light should be in reach for the resident.	F 0558	**Munster Med-Inn** **Annual Survey: 8/23/2021** Please accept the following as the facility's credible allegation of compliance. This plan of correction does not constitute an admission of guilt or liability by the facility and is submitted only in response to the regulatory requirement. **F558 Reasonable accommodations of Needs/Preferences** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;** Resident 143- call light was immediately placed within resident reach. **How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken;** All residents have the potential to be affected by the same alleged deficient practice. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur;** Staff were re-educated on ensuring	09/03/2021

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	3.1-3(v)(1)		resident call lights positioned within reach while in their room. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance programs will be put into place;** Facility angels will complete round observations for 15 residents 3 times per week to ensure call light is within resident reach. Administrator/designee will present a summary of the audits to the Quality Assurance committee monthly for 6 months. Thereafter, if determined by the Quality Assurance committee, auditing and monitoring will be done quarterly and present quarterly at the QA meeting. Monitoring will be on going. **Date by which systemic corrections will be completed: 9/3/2021**	
F 0561 SS=D Bldg. 00	483.10(f)(1)-(3)(8) Self-Determination §483.10(f) Self-determination. The resident has the right to and the facility must promote and facilitate resident self-determination through support of resident choice, including but not limited to the rights specified in paragraphs (f)(1) through (11) of this section. §483.10(f)(1) The resident has a right to choose activities, schedules (including sleeping and waking times), health care and			

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	providers of health care services consistent with his or her interests, assessments, and plan of care and other applicable provisions of this part. §483.10(f)(2) The resident has a right to make choices about aspects of his or her life in the facility that are significant to the resident. §483.10(f)(3) The resident has a right to interact with members of the community and participate in community activities both inside and outside the facility. §483.10(f)(8) The resident has a right to participate in other activities, including social, religious, and community activities that do not interfere with the rights of other residents in the facility. Based on record review and interview, the facility failed to ensure resident choices were honored related to bathing preferences for 1 of 3 residents reviewed for choices. (Resident 82) Finding includes: Interview with the resident, on 8/17/21 at 9:01 a.m., indicated she preferred showers, but had not had one for several weeks. Resident 82's record was reviewed on 8/18/21 at 9:10 a.m. Diagnoses included, but were not limited to, chronic pain syndrome and osteoarthritis. The Quarterly Minimum Data Set (MDS) assessment, dated 6/11/21, indicated the resident was cognitively intact and required extensive two person assistance for bed mobility and transfers. The Plan of Care Card, dated 3/29/21, indicated the	F 0561	**Munster Med-Inn** **Annual Survey: 8/23/2021** Please accept the following as the facility's credible allegation of compliance. This plan of correction does not constitute an admission of guilt or liability by the facility and is submitted only in response to the regulatory requirement. **F561 Self Determination** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;** Resident preferences were reviewed with focus on showers and updated for Resident 82. **How the facility will identify**	09/03/2021

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	resident preferred showers. The shower book indicated the resident was to have a shower on Monday and Thursday. The Point of Care electronic charting (where CNAs document their tasks completed) indicated the resident had received bed baths or partial bed baths in the past 30 days. There were no showers documented. Interview with the 300 Unit Manager, on 8/19/21 at 9:25 a.m., indicated the resident used to be a hoyer lift (mechanical lift) for transfers, and was recently changed to a sit-to-stand lift for transfers. She agreed the resident could still have been given a shower. 3.1-3(u)(1)		**other residents having the potential to be affected by the same deficient practice and what corrective action will be taken;** All residents have the potential to be affected by the same alleged deficient practice. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur;** Clinical and non-clinical staff were re-educated on providing care per resident's self- determined preferences including bathing preferences. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance programs will be put into place;** Activities Director/designee will audit the residents who have a quarterly MDS due that week to identify/review residents' self-determined preferences. Administrator/designee will present a summary of the audits to the Quality Assurance committee monthly for 6 months. Thereafter, if determined by the Quality Assurance committee, auditing and monitoring will be done quarterly and present quarterly at the QA meeting. Monitoring will be on going.	

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			Date by which systemic corrections will be completed: 9/3/2021	
F 0577 SS=C Bldg. 00	483.10(g)(10)(11) Right to Survey Results/Advocate Agency Info §483.10(g)(10) The resident has the right to- (i) Examine the results of the most recent survey of the facility conducted by Federal or State surveyors and any plan of correction in effect with respect to the facility; and (ii) Receive information from agencies acting as client advocates, and be afforded the opportunity to contact these agencies. §483.10(g)(11) The facility must-- (i) Post in a place readily accessible to residents, and family members and legal representatives of residents, the results of the most recent survey of the facility. (ii) Have reports with respect to any surveys, certifications, and complaint investigations made respecting the facility during the 3 preceding years, and any plan of correction in effect with respect to the facility, available for any individual to review upon request; and (iii) Post notice of the availability of such reports in areas of the facility that are prominent and accessible to the public. (iv) The facility shall not make available identifying information about complainants or residents. Based on observation and interview, the facility failed to have the most recent results of the State survey findings readily available for review. This had the potential to affect the 180 residents who resided in the facility. Finding includes:	F 0577	**Munster Med-Inn** **Annual Survey: 8/23/2021** Please accept the following as the facility's credible allegation of compliance. This plan of correction does not constitute an	09/03/2021

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	On 8/19/21 at 2:29 p.m. a Resident Council Meeting was conducted with five residents. All five residents were unaware of where to find the most recent State survey results. On 8/19/21 at 3:14 p.m., the State survey results binder that was supposed to be located at the reception desk and in the front lobby per the sign posted, could not be found. Interview with the Administrative Assistant, indicated the book was normally on the end of the desk and she did not know where it currently was. Interview with the Administrator on 8/19/21 at 3:14 p.m., indicated he had the book in his office. The last survey result located in the binder was dated 8/5/20. The survey results binder lacked the reports from previously completed surveys on 6/10/21, 3/23/21, and 1/8/21. 3.1-3(b)(1)		admission of guilt or liability by the facility and is submitted only in response to the regulatory requirement. **F577 Right to Survey results/Advocate Agency info** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;** Facility Survey result binder was immediately updated and made available for resident, visitor, and staff. **How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken;** All residents have the potential to be affected by the same alleged deficient practice. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur;** Administrator reviewed survey result regulation. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance programs will be put into place;** Administrator/designee will visualize survey binder is in designated area and available for	

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			viewing weekly. Administrator/designee will review survey binder to ensure current survey results are in binder weekly. Administrator/designee will present a summary of the audits to the Quality Assurance committee monthly for 6 months. Thereafter, if determined by the Quality Assurance committee, auditing and monitoring will be done quarterly and present quarterly at the QA meeting. Monitoring will be on going. **Date by which systemic corrections will be completed: 9/3/2021**	
F 0623 SS=B Bldg. 00	483.15(c)(3)-(6)(8) Notice Requirements Before Transfer/Discharge §483.15(c)(3) Notice before transfer. Before a facility transfers or discharges a resident, the facility must- (i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman. (ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and (iii) Include in the notice the items described in paragraph (c)(5) of this section. §483.15(c)(4) Timing of the notice.			

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	(i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged. (ii) Notice must be made as soon as practicable before transfer or discharge when- (A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section; (B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section; (C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section; (D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or (E) A resident has not resided in the facility for 30 days. §483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following: (i) The reason for transfer or discharge; (ii) The effective date of transfer or discharge; (iii) The location to which the resident is transferred or discharged; (iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request; (v) The name, address (mailing and email)			

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	and telephone number of the Office of the State Long-Term Care Ombudsman; (vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and (vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act. §483.15(c)(6) Changes to the notice. If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available. §483.15(c)(8) Notice in advance of facility closure In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(l).			

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	Based on record review and interview, the facility failed to ensure a resident's Responsible Party was notified in writing related to a transfer to the hospital for 4 of 5 residents reviewed for hospitalization. (Residents 14, 15, 102, and 81) Findings include: 1. The record for Resident 14 was reviewed on 8/18/21 at 2:11 p.m. Diagnoses included, but were not limited to, neurogenic bladder, disorders of the bladder and sepsis. The Annual Minimum Data Set (MDS) assessment, dated 5/10/21, indicated the resident was severely impaired for daily decision making. Nurses' Notes, dated 6/24/21 at 5:00 p.m., indicated the resident was responsive, but much more lethargic than her norm. The resident's eyes were closed and she did not follow simple commands. The resident was pale and her skin was warm to touch. Her temperature was 102.3, heart rate 124, and respirations were 24. Orders were received to send the resident to the hospital to be evaluated and treated for possible sepsis. The transfer/discharge paperwork along with the bedhold policy was given to the EMT. They were instructed to give the information to the emergency room nurse upon arrival. Nurses' Notes, dated 8/8/21 at 8:32 p.m., indicated the resident was in bed and noted to be very drowsy, verbally non-responsive, and slow to respond to verbal and tactile stimulation. The resident's Physician was notified and orders were received to send the resident to the emergency room for evaluation. The resident's daughter was	F 0623	**Munster Med-Inn** **Annual Survey: 8/23/2021** Please accept the following as the facility's credible allegation of compliance. This plan of correction does not constitute an admission of guilt or liability by the facility and is submitted only in response to the regulatory requirement. **F623 Notice Requirements Before Transfer/Discharge** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;** Facility notice of transfer discharge including the bed hold policies were mailed to the responsible parties for Residents 102, 14, 15, and 81. **How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken;** All residents that are transferred or discharged have the potential to be affected by the same alleged deficient practice. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur;** Staff were re-educated providing the notice of transfer discharge	09/03/2021

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	also notified. There was no documentation indicating the resident's Responsible Party had been sent a copy of the transfer/discharge notice for both hospitalizations. Interview with the Director of Nursing on 8/23/21 at 9:20 a.m., indicated the resident received a copy of her transfer notice but there was no documentation indicating a copy was mailed to her family.2. The record for Resident 15 was reviewed on 8/19/21 at 9:15 a.m. Diagnoses included, but were not limited to, traumatic subdural hemorrhage with loss of consciousness, major depressive disorder, dementia with behavioral disturbance, atrial fibrillation, heart failure, high blood pressure, repeated falls, stroke, and type 2 diabetes. The Quarterly Minimum Data Set (MDS) assessment, dated 7/8/21, indicated the resident was not alert and oriented. Nurses' Notes, dated 3/22/21 at 3:33 a.m., indicated the resident was found on the floor by the CNA. The resident was bleeding from the back of her head. 911 was called. Nurses' Notes, dated 3/22/21 at 4:03 a.m., indicated 911 was at the facility to transport the resident to the emergency room. At 4:11 a.m., the resident's responsible party was made aware the resident was being sent to the hospital due to a fall. Nurses' Notes, dated 3/22/21 at 8:50 a.m., indicated the facility was informed the resident had no fractures, but was being admitted to the hospital.		including the bed hold policy to the resident/ resident responsible party upon transfer and discharge from facility. Facility H.I.M was educated to mail (Via USPS) a copy of the notice of discharge including the Bed hold packet to the resident's responsible party within 72 hours of the resident's transfer and uploaded into the residents medical record. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance programs will be put into place;** Administrator/Designee will audit weekly to ensure the notice of transfer discharge including bed hold polices are provided to resident responsible parties upon transfer/discharge. The Administrator/designee will present a summary of the audits to the Quality Assurance committee monthly for 6 months. Thereafter, if determined by the Quality Assurance committee, auditing and monitoring will be done quarterly and present quarterly at the QA meeting. Monitoring will be on going. **Date by which systemic corrections will be completed: 9/3/2021**	

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	There was no documentation the State transfer form was mailed to the resident's family after she had been admitted to the hospital. Interview with the 2nd floor Unit Manager on 8/19/21 at 10:45 a.m., indicated the nursing staff completed the State transfer form and sent it with the resident to the hospital, but there was no documentation the form was mailed to the resident's family. 3. The record for Resident 102 was reviewed on 8/19/21 at 10:55 a.m. Diagnoses included, but were not limited to, stroke, osteomyelitis, peripheral vascular disease, peripheral artery disease, dementia without behavioral disturbance, high blood pressure, major depressive disorder, and dysphagia. The Quarterly Minimum Data Set (MDS) assessment, dated 8/4/21, indicated the resident was not alert and oriented. Nurses' Notes, dated 5/29/21 at 11:46 a.m., indicated during a routine wound care visit, it had been noted the wound to the left 1st toe had declined and the reddened area had now reached the left lower leg/ankle. It was very tender with cleansing. The Wound Physician was notified and suggested the resident start back on intravenous antibiotics and if the redness still persisted, to send the resident to the hospital. Nurses' Notes, dated 5/29/21 at 12:41 p.m., indicated the resident's primary physician was notified and given an update. New orders to send the resident to the hospital were obtained. . Nurses' Notes, dated 5/29/21 at 12:50 p.m., indicated the resident's power of attorney was			

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	notified and given an update regarding the resident's toe and hospitalization. Nurses' Notes, dated 5/29/21 at 7:00 p.m., indicated the resident was admitted to the hospital with the diagnosis of osteomyelitis of the left ankle/foot. There was no documentation the State transfer form was mailed to the resident's power of attorney after she had been admitted to the hospital. Interview with the 5th floor Unit Manager on 8/19/21 at 12:32 p.m., indicated she was not able to find a copy of the State transfer form in the chart, and she was not sure if the resident's family were mailed a copy of the form . An Interview on 8/23/21 at 11:47 a.m., with the resident's power of attorney, indicated he did not remember ever receiving any paper work or the State transfer form in the mail while the resident was in the hospital.4. The record for Resident 81 was reviewed on 8/19/21 at 4:28 p.m. Diagnoses included, but were not limited to, dementia and urinary tract infection. The Quarterly Minimum Data Set (MDS) assessment, dated 7/6/21, indicated the resident was severely impaired for daily decision making. Nurses' Notes, dated 8/6/21 at 8:00 p.m., indicated the resident was yelling out in pain and complaining of not feeling well. Upon assessment, the resident was observed guarding her abdomen, writer noted her abdomen was hard to touch to the upper right quadrant, mildly distended to upper right quadrant, rest of abdomen round and soft to touch. The resident			

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	was complaining of pain as the right upper quadrant area was palpated. Bowel sounds were noted in all 4 quadrants. The Physician was notified of the resident's status and orders were received to send the resident to the hospital for evaluation. The resident's daughter was notified as well. The resident was sent to the hospital with a copy of her bedhold notice as well as the transfer/discharge notice. There was no documentation indicating the resident's daughter had been given a written copy of the transfer/discharge notice. Interview with Social Service Employee 1 on 8/20/21 at 10:10 a.m., indicated the paperwork was supposed to be mailed to the Responsible Party if they did not go with the resident to the hospital. The paperwork was to be mailed within 72 hours. 3.1-12(a)(6)(ii) 3.1-12(a)(6)(iii)			
F 0641 SS=A Bldg. 00	483.20(g) Accuracy of Assessments §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. Based on observation, record review and interview, the facility failed to ensure the Minimum Data Set (MDS) comprehensive assessment was accurately completed related to medications and restraints for 2 of 37 MDS assessments reviewed. (Residents 5 and 15) Findings include: 1. The record for Resident 5 was reviewed on 8/19/21 at 2:15 p.m. Diagnoses included, but were not limited to, type 2 diabetes mellitus and	F 0641	**Munster Med-Inn** **Annual Survey: 8/23/2021** Please accept the following as the facility's credible allegation of compliance. This plan of correction does not constitute an admission of guilt or liability by the facility and is submitted only in response to the regulatory requirement. **F641 Accuracy of Assessments**	09/03/2021

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	dementia with behavior disturbance. The Quarterly Minimum Data Set (MDS) assessment, dated 5/26/21, indicated the resident was cognitively impaired for daily decision making. Section N-Medications, indicated the resident had received insulin injections the last 7 days. A Physician's Order, dated 1/15/19 and listed as current on the 8/2021 Physician's Order Summary (POS), indicated the resident was to receive Victoza (a non-insulin type 2 diabetic control medication) 1.8 milligrams (mg) subcutaneously at bedtime. Interview with the Director of Nursing on 8/23/21 at 10:40 a.m., indicated Victoza was not classified as insulin and the resident's MDS would be corrected. 2. The record for Resident 15 was reviewed on 8/19/21 at 9:15 a.m. Diagnoses included, but were not limited to, traumatic subdural hemorrhage with loss of consciousness, major depressive disorder, dementia with behavioral disturbance, atrial fibrillation, heart failure, high blood pressure, repeated falls, stroke, and type 2 diabetes. The Quarterly Minimum Data Set (MDS) assessment, dated 4/9/21, indicated "other" restraint was used less than daily. Physician's Orders, dated 4/2021, indicated there were no orders for a restraint. Interview with the MDS Coordinator on 8/18/21 at 2:10 p.m., indicated the resident had never had a restraint and it was "human error" the other restraint was marked on the Quarterly MDS assessment.		**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;** MDS for resident 5 and 15 were modified. **How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken;** All residents have the potential to be affected by the same alleged deficient practice. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur;** MDS staff were re-educated on ensuring the MDS is accurate and reflect the resident's current status at the time of MDS completion. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance programs will be put into place;** MDS/designee will audit 5 MDS's completed weekly including all types of MDS Assessments to ensure the accuracy of the MDS for all areas. Any non-compliance will be corrected. Auditors will not audit their own work.	

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	3.1-31(i)		MDS/designee will present a summary of the audits to the Quality Assurance committee monthly for 6 months. Thereafter, if determined by the Quality Assurance committee, auditing and monitoring will be done quarterly and present quarterly at the QA meeting. Monitoring will be on going. **Date by which systemic corrections will be completed: 9/3/2021**	
F 0657 SS=E Bldg. 00	483.21(b)(2)(i)-(iii) Care Plan Timing and Revision §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in			

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	disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. Based on record review and interview, the facility failed to provide documentation of care conferences held with the resident and facility staff for 5 of 6 residents reviewed for care planning decisions. (Residents 37, D, C, 140 and 166) The facility also failed to ensure Care Plans were revised as needed related to medication use for 2 of 37 Care Plans reviewed. (Residents 72 and 123) Findings include: 1. The record for Resident 72 was reviewed on 8/18/21 at 1:01 p.m. Diagnoses included, but were not limited to, atrial fibrillation (irregular heart beat) and long term use of anticoagulants (blood thinner). The Quarterly Minimum Data Set (MDS) assessment, dated 7/16/21, indicated the resident was cognitively impaired for daily decision making. A Care Plan, dated 1/11/21 and reviewed on 8/2/21, indicated the resident had a potential for complications related to anticoagulant therapy. A Physician's Order, dated 3/5/21, indicated the resident's Eliquis (a blood thinner) had been discontinued. Interview with the Director of Nursing on 8/23/21 at 10:40 a.m., indicated the resident's Care Plan needed to be updated.	F 0657	**Munster Med-Inn** **Annual Survey: 8/23/2021** Please accept the following as the facility's credible allegation of compliance. This plan of correction does not constitute an admission of guilt or liability by the facility and is submitted only in response to the regulatory requirement. **F657 Care Plan Timing and Revision** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;** Care plans were immediately updated for Residents 72 and 123. Care conferences invitations were sent for Residents 140, C, D, 37, and 166 this includes invitations to both the resident and responsible party. **How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken;** All residents have the potential to be affected by this alleged deficient practice.	09/03/2021

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	2. The record for Resident 123 was reviewed on 8/19/21 at 9:26 a.m. Diagnoses included, but were not limited to, dementia with behavior disturbance and altered mental status. The Annual Minimum Data Set (MDS) assessment, dated 5/28/21, indicated the resident was moderately impaired for daily decision making. A Care Plan, dated 7/29/21, indicated the resident had a potential for side effects related to the use of an antibiotic. Interventions included, but were not limited to, administer antibiotic treatment as ordered by the Physician. Document response to treatment. Nurses' Notes, dated 8/4/21 at 8:06 p.m., indicated the resident had received his last dose of antibiotic. The resident received Ciprofloxacin (an antibiotic) 0.2% ear drops to the right ear 7/28 through 8/4/21. Interview with the Director of Nursing on 8/23/21 at 10:40 a.m., indicated the resident's Care Plan would be updated related to the antibiotic use. 3. During an interview, on 8/16/21 at 11:51 a.m., Resident 37 indicated he had not been invited to or had a care conference. The record for Resident 37 was reviewed on 8/18/21 at 10:51 a.m. Diagnoses included, but were not limited to, stroke, peripheral vascular disease, abnormal coagulation, and atherosclerotic heart disease of native coronary artery without angina pectoris.		**What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur;** Staff responsible for reviewing and revising care plans based on resident's assessments have been re-educated on updating care plans timely. Staff responsible for hosting care plan conferences were re-educated on ensuring the resident, responsible party, and members of the IDT are involved/invited to the care conferences. Care conference attendees should be documented accordingly. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance programs will be put into place;** Nurse manager/designee will conduct weekly audits of care plans for 10 different residents each week to ensure care plans are reviewed and revised based on resident assessments. The Social Service Director/designee will audit care conference's weekly to ensure resident, responsible party, and members of the IDT attendance is documented. The DON/designee will present a summary of the audits to the Quality Assurance committee	

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	The Quarterly Minimum Data Set (MDS) assessment, dated 6/18/21, indicated the resident's short and long term memory was ok and he was independent for decision making. There was no documentation in the last 6 months the resident had a care conference. Interview with the 4th Floor Unit Manager on 8/19/21 at 3:30 p.m., indicated there was no documentation the resident had a care conference. 4. During an interview on 8/17/21 at 8:43 a.m., Resident D indicated she was not invited to or had a care conference. The record for the Resident D was reviewed on 8/20/21 at 10:23 a.m. Diagnoses included, but were not limited to, end stage renal disease, dependence on renal dialysis, anemia, heart failure, type 2 diabetes, weakness, need for assistance with personal care, major depressive disorder, legal blindness, and chronic pain. The Annual Minimum Data Set (MDS) assessment, dated 6/4/21, indicated the resident was alert and oriented. There was no documentation the resident had a care conference in the last 6 months. Interview with the 4th Floor Unit Manager on 8/19/21 at 3:30 p.m., indicated there was no documentation the resident had a care conference or was invited to one. 5. During an interview on 8/16/21 at 2:40 p.m., Resident C indicated he had not been invited to or had a care conference.		monthly for 6 months. Thereafter, if determined by the Quality Assurance committee, auditing and monitoring will be done quarterly and present quarterly at the QA meeting. Monitoring will be on going. **Date by which systemic corrections will be completed: 9/3/2021**	

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	The record for Resident C was reviewed on 8/19/21 at 2:25 p.m. Diagnoses included, but were not limited to, hydronephrosis with renal and ureteral calculous obstruction, anxiety disorder, dependence on renal dialysis, acute kidney failure, peripheral vascular disease, heart failure, end stage renal disease, type 2 diabetes and the need for assistance with personal care. The Quarterly Minimum Data Set (MDS) assessment, dated 7/2/21, indicated the resident was alert and oriented. There was no documentation the resident had a care conference or was invited to his care conference in the last 6 months. Interview with the 4th Floor Unit Manager on 8/19/21 at 3:30 p.m., indicated there was no documentation the resident was invited or had a care conference.6. Interview with Resident 140 on 8/16/21 at 11:55 a.m., indicated he was not aware of being invited to his Care Plan Conferences. The record for Resident 140 was reviewed on 8/18/21 at 11:00 a.m. Diagnoses included, but were not limited to, high blood pressure and edema. The Quarterly Minimum Data Set (MDS) assessment, dated 7/27/21, indicated the resident was cognitively intact for daily decision making. There was no documentation in the resident's record of a recent care conference. Interview with Social Service Employee 2 on 8/18/21 at 11:13 a.m., indicated if the resident would have had a care conference, she would have put a note under Care Plan Conference, who			

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	attended, and if the resident declined. The front desk scheduled the Care Conferences. Interview with the Administrative Assistant on 8/18/21 at 11:43 a.m., indicated the resident should have had a Care Conference in June. 7. Interview with Resident 166 on 8/16/21 at 2:37 p.m., indicated he had not recently been invited to his Care Conference. The record for Resident 166 was reviewed on 8/18/21 at 11:05 a.m. Diagnoses included, but were not limited to, renal failure, high blood pressure and diabetes mellitus. The Quarterly Minimum Data Set (MDS) assessment, dated 7/25/21, indicated the resident was cognitively intact for daily decision making. Interview with Social Service Employee 2 on 8/18/21 at 11:10 a.m., indicated the front desk scheduled the Care Conferences. She then received a memo of the date and time of the conference. She was not sure if the resident would receive a letter but she indicated his wife would. She indicated she was unable to locate documentation of the resident's last Care Conference and if he was invited. Interview with the Administrative Assistant on 8/18/21 at 11:51 a.m., indicated the resident's last Care Conference was in June and a letter was sent to his spouse. She indicated it was up to Social Service Staff to invite the resident. Interview with the Director of Nursing on 8/18/21 at 12:17 p.m., indicated Social Services was to tell the residents about their Care Plan meetings. If the family was unable to attend, Social Services			

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	spoke to the resident themselves if they were alert and oriented. 3.1-35(d)(2)(B)			
F 0677 SS=E Bldg. 00	483.24(a)(2) ADL Care Provided for Dependent Residents §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; Based on observation, record review and interview, the facility failed to ensure dependent residents received assistance with ADL's (activities of daily living) related to shaving, nail care, and bathing for 4 of 8 residents reviewed for ADL's. (Residents E, D, C, and F) Findings include: 1. On 8/16/21 at 12:03 p.m., Resident E was observed in bed. His fingernails were long and dirty and he was unshaven. On 8/17/21 at 8:45 a.m. and 2:40 p.m., the resident was observed in bed. His fingernails were long and dirty and he was unshaven. On 8/18/21 at 8:50 a.m. and 10:45 a.m., the resident was observed in bed. His fingernails were long and dirty and he was unshaven. On 8/19/21 at 8:50 a.m., the resident was observed in bed. His fingernails were long and dirty and he was unshaven. The record for Resident E was reviewed on 8/17/21 at 3:00 p.m. Diagnoses included, but were not limited to, femur fracture, weakness,	F 0677	**Munster Med-Inn** **Annual Survey: 8/23/2021** Please accept the following as the facility's credible allegation of compliance. This plan of correction does not constitute an admission of guilt or liability by the facility and is submitted only in response to the regulatory requirement. **F677 ADL Care Provided for Dependent Residents** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;** Resident E was assisted with shaving and fingernails were cleaned and trimmed. Resident D was assisted with showering per resident preference. Resident C was assisted with cleaning and trimming fingernail, provided a bed bath as preferred, and hair was washed. Resident F was assisted with	09/03/2021

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	dysphagia, need for assistance with personal care, dementia, anxiety disorder, major depressive disorder, hearing loss, and legal blindness. The Quarterly Minimum Data Set (MDS) assessment, dated 7/4/21, indicated the resident was not alert and oriented and had short and long term memory problems. The resident was severely impaired for decision making. The resident was an extensive assist with 2 person physical assist for transfers, and totally dependent on staff with 1 assist for toileting and personal hygiene. The resident needed limited assist with 1 person physical assist for eating. Interview with the 4th floor Unit Manager on 8/19/21 at 8:52 a.m., indicated the resident was dependent on staff for all of his personal hygiene. He was unshaven and his fingernails were long and dirty and in need of being trimmed. 2. During an interview with Resident D on 8/17/21 at 8:39 a.m., she indicated she would like more showers per week. The record for the Resident D was reviewed on 8/20/21 at 10:23 a.m. Diagnoses included, but were not limited to, end stage renal disease, dependence on renal dialysis, anemia, heart failure, type 2 diabetes, weakness, need for assistance with personal care, major depressive disorder, legal blindness, and chronic pain. The Annual Minimum Data Set (MDS) assessment, dated 6/4/21, indicated the resident was alert and oriented. The resident was totally dependent with 1 person physical assist for bathing. The July 2021 shower schedule, indicated the		shaving. **How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken;** All dependent residents have the potential to be affected by the same alleged deficient practice. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur;** Staff were re-educated on providing residents with assistance with ADLs per resident's plan of care including showers, shaving, and nail care. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance programs will be put into place;** Facility Angels will Audit 15 residents 5 times weekly with a focus on dependent resident's requiring ADL assistance to ensure showers including hair washing, nail care, shaving, and assistance with all ADLs are provided per plan of care. Nurse managers will audit 5 residents showers, nail care, and hair washing weekly to ensure they are provided. Director of Nursing/designee will present a summary of the audits	

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(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
	resident received a shower on 7/6, 7/13, refused on 7/23 and had a complete bed bath on 7/24/21. No other showers or complete bed baths were completed for the month. The August 2021 shower schedule, indicated the resident received a complete bed bath on 8/7, 8/8, 8/13, 8/16, and 8/17/21. The resident preferred showers. Interview with the 4th Floor Unit Manager on 8/20/21 at 10:35 a.m., indicated the resident was not bathed at least 2 times a week for the months of July and August 2021. 3. During an interview with Resident C on 8/16/21 at 2:34 p.m., he indicated his nails were long and dirty and his hair had not been washed in a very long time. His preference was to receive a complete bed bath. The record for Resident C was reviewed on 8/19/21 at 2:25 p.m. Diagnoses included, but were not limited to, hydronephrosis with renal and ureteral calculous obstruction, anxiety disorder, dependence on renal dialysis, acute kidney failure, peripheral vascular disease, heart failure, end stage renal disease, type 2 diabetes and the need for assistance with personal care. The Quarterly Minimum Data Set (MDS) assessment, dated 7/2/21, indicated the resident was alert and oriented. He was an extensive assist with 1 person physical assist for personal hygiene and totally dependent on staff for bathing. The Admission MDS assessment, dated 2/14/21, indicated the resident was alert and oriented and it was very important for them to choose whether to take a shower or bed bath.		to the Quality Assurance committee monthly for 6 months. Thereafter, if determined by the Quality Assurance committee, auditing and monitoring will be done quarterly and present quarterly at the QA meeting. Monitoring will be on going. **Date by which systemic corrections will be completed: 9/3/2021**	

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	155131	A. BUILDING 00 B. WING	08/23/2021

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	The resident received 7 complete bed baths in the month of 7/2021 and 5 complete bed baths 8/1-8/18/21. There was no documentation he had his hair washed each time. Interview with the 4th Floor Unit Manager on 8/20/21 at 10:15 a.m., indicated he had trimmed his nails on Wednesday, but did indicate they were very dirty and needed to be soaked. He does not know when the last time his hair was washed and confirmed the resident's hair should be washed during the complete bed baths.4. On 8/16/21 at 2:37 p.m., Resident F was observed lying in bed watching television. He was unshaven with a large amount of facial hair on his face, chin, and neck. He indicated he wanted help shaving his beard because he couldn't do it himself since his hands were too shaky. There was a male CNA who would come around and shave him sometimes, but no one had offered to assist him with shaving in a while. On 8/18/21 at 10:33 a.m., the resident was observed lying in bed watching television. He remained unshaven with a large amount of facial hair on his face, chin, and neck. He indicated he had received a bed bath earlier in the morning, but the CNA had not offered to shave him. He would like his beard shaved. The resident's record was reviewed on 8/18/21 at 1:55 p.m. Diagnoses included, but were not limited to, essential tremor, anxiety disorder, and type 2 diabetes mellitus. The Admission Minimum Data Set (MDS) assessment, dated 6/27/21, indicated the resident was cognitively intact. He required an extensive assist of one with personal hygiene and was			

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	totally dependent on staff for bathing. The Bath and Skin Report sheet indicated the resident was to receive bathing on Tuesdays and Fridays on the 3-11 shift. The bathing had been signed off as completed on 8/3/21 and indicated the resident had not been shaved that day. The sheet had the dates of 8/6/21, 8/10/21, 8/13/21, and 8/17/21 written in but no bathing or shaving had been checked off as completed or signed by staff. The computer ADL documentation, dated 8/18/21, indicated the resident had received a complete bed bath. There was lack of documentation that the resident had been shaved or offered assistance with shaving. Interview with the 3rd floor Unit Manager on 8/18/21 at 11:43 a.m., indicated there was a restorative CNA who the resident liked to shave him because he had electric clippers, so the other CNA's probably assumed he wanted to wait for that CNA to shave him. She indicated the bathing record documentation was incomplete and could not verify if staff had offered to shave the resident. This Federal tag relates to Complaint IN00358590. 3.1-38(a)(3)(B) 3.1-38(a)(3)(D) 3.1-38(a)(3)(E)			
F 0684 SS=E Bldg. 00	483.25 Quality of Care § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the			

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	facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. Based on observation, record review and interview, the facility failed to assess and monitor areas of bruising, as well as ensure geri sleeves and compression stockings were in use and treatments were completed as ordered for 7 of 11 residents reviewed for skin conditions (non-pressure related). (Residents 51, 65, 72, 37, 102, 82, and 143) Findings include: 1. On 8/16/21 at 10:54 a.m., Resident 51 was observed to have multiple areas of reddish/purple bruising to her left forearm and hand. On 8/18/21 at 11:57 a.m., the resident was in her room seated in her wheelchair. The areas of reddish/purple discoloration remained to her left forearm and hand. Geri sleeves (protective arm coverings) were on the resident's bed. At 4:15 p.m., the resident was in the lounge area, her geri sleeves remained off. On 8/19/21 at 9:00 a.m. and 10:58 a.m., the resident was in her bed sleeping. The areas of discoloration remained to her left forearm and hand. The geri sleeves were not in use. The record for Resident 51 was reviewed on 8/20/21 at 10:58 a.m. Diagnoses included, but were not limited to, dementia with behavior disturbance and anemia. The Quarterly Minimum Data Set (MDS) assessment, dated 7/29/21, indicated the resident	F 0684	**Munster Med-Inn** **Annual Survey: 8/23/2021** Please accept the following as the facility's credible allegation of compliance. This plan of correction does not constitute an admission of guilt or liability by the facility and is submitted only in response to the regulatory requirement. **F684 Quality of Care** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;** Resident 51- The bruises to the Left forearm and hand were assessed and new orders were received to monitor bruises. Geri sleeves were applied as ordered. Care plan for aspirin initiated. Resident 65- Bruising to top of hand was assessed. The physician was notified and new orders were received to monitor and appl Geri-Sleeves care plan was updated. Resident 72- Left and Right forearm bruising was assessed/Geri-sleeves were applied and new orders were received to monitor bruising. A new care plan was initiated. Resident 37- Was reimbursed for	09/03/2021

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	was cognitively impaired for daily decision making. The resident required extensive assistance with bed mobility and transfers. A Physician's Order, dated 3/12/20 and listed as current on the 8/2021 Physician's Order Summary (POS), indicated the resident was to have geri sleeves to both of her arms. The resident was also receiving 81 milligrams (mg) of Aspirin daily. There was no current order to monitor the bruising on the resident's left arm and hand. Nurses' Notes, for the month of August 2021, indicated there was no documentation related to the left arm and hand bruising. Interview with the MCU Unit Manager on 8/20/21 at 10:20 a.m., indicated the resident's bruising should have been assessed and monitored and her geri sleeves should have been applied as ordered. Nurses' Notes, dated 8/20/21 at 12:41 p.m., indicated the resident had two bruises that were circular to the left upper middle arm that were light purple and green that were fading. The Physician was notified and orders were obtained to monitor the bruising. A Care Plan related to Aspirin therapy was also initiated on 8/20/21. 2. On 8/17/21 at 10:59 a.m., Resident 65 was observed with large areas of reddish discoloration to the top of both of his hands. At 2:48 p.m., the discoloration remained unchanged. On 8/18/21 at 11:58 a.m. and 4:15 p.m., the discoloration remained unchanged to both hands.		the rash cream. The rash has resolved. Orders were received to monitor the bruise to the right hand between thumb and index finger. Resident 102- Left foot dressing was immediately changed. Treatments are being completed as ordered for the left heel and left first toe. Resident 82- Had compression stockings applied to both lower extremities. The compression stocking order was transferred to the Medication Administration Record. Resident 143- Coban self-adherent wrap was re-applied and both arms were covered with Geri-sleeves. **How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken;** All residents have the potential to be affected by the same alleged deficient practice. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur;** Staff were re-educated on ensuring geri- sleeves and ted hose are in place as per orders. Nurses were re-educated on addressing and assessing changes in skin condition,	

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	On 8/19/21 at 9:00 a.m. and 10:58 a.m., the resident had fading reddish discoloration to both of his hands. The record for Resident 65 was reviewed on 8/18/21 at 12:28 p.m. Diagnoses included, but were not limited to, dementia without behavior disturbance and anemia. The Quarterly Minimum Data Set (MDS) assessment, dated 7/15/21, indicated the resident was cognitively impaired and he required supervision with bed mobility and transfers. A Physician's Order, dated 6/18/21, indicated the resident received 81 milligrams (mg) of Aspirin daily. There were no orders to monitor the bruising to his hands. Nurses' Notes, dated 8/13/21 at 10:15 a.m., indicated the bruise to his upper left arm was no longer present and there was no further need to monitor. There was no documentation in the nursing progress notes related to the hand discoloration. Interview with the MCU Unit Manager on 8/20/21 at 10:15 a.m., indicated the resident had a history of purpura and that was what was on his hands. She indicated his diagnoses and care plan needed to be updated to reflect this. Nurses' Notes, dated 8/20/21 at 10:22 a.m., indicated the resident had bruising to the left posterior arm that was light purple and red color , the left lower hand also had bruising that was fading yellow and green. The right lower wrist		obtaining orders for treatment, implementation of treatment, treatments and interventions are in place per physician orders and/or re-applied if missing. Assistive clinical staff were educated on notifying the nurse of any change in skin condition **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance programs will be put into place;** Facility Angels/ designee will complete observation rounds on 15 residents 3 times per week to ensure areas of bruising as assessed and new physician orders are in place, existing treatments are in place or re-applied, and geri- sleeves and ted hose are in place. Director of Nursing/designee will present a summary of the audits to the Quality Assurance committee monthly for 6 months. Thereafter, if determined by the Quality Assurance committee, auditing and monitoring will be done quarterly and present quarterly at the QA meeting. Monitoring will be on going. **Date by which systemic corrections will be completed: 9/3/2021**	

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	was reddish/purple in color. The Physician was notified and orders were obtained to monitor the bruising and geri sleeves while awake. A Care Plan related to Aspirin therapy was also initiated on 8/20/21. 3. On 8/17/21 at 10:43 a.m., Resident 72 was observed with areas of reddish/purple bruising to her left and right forearms. On 8/19/21 at 10:58 a.m., the resident was observed with reddish/purple bruising to her left forearm area. She was not wearing a geri sleeve on her left arm but did have one on the right arm. At 1:15 pm, the geri sleeve to the left arm remained off. Multiple areas of reddish/purple discoloration were observed to the left hand, wrist and forearm. The resident also had some bruising to the fingers on her left hand and a scab was noted on her middle finger. The record for Resident 72 was reviewed on 8/18/21 at 1:01 p.m. Diagnoses included, but were not limited to, atrial fibrillation and long term anticoagulant (blood thinner) use. The Quarterly Minimum Data Set (MDS) assessment, dated 7/16/21, indicated the resident was cognitively impaired and she required extensive assistance with bed mobility and transfers. A Physician's Order, dated 3/5/21, indicated the resident was to receive 81 milligrams (mg) of Aspirin daily. A Physician's Order, dated 5/11/21, indicated the resident was to have geri sleeves to the bilateral upper extremities every shift.			

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Nurses' Notes, dated 8/13/21 at 10:30 a.m., indicated the bruise to the resident's left hand and leg had healed.

There were no current orders to monitor the bruising and there was no documentation of the bruising in the nursing progress notes.

Interview with the MCU Unit Manager on 8/20/21 at 10:20 a.m., indicated the resident's bruising should have been monitored and if the CNAs noticed any skin discolorations during care, they were to notify nursing. She also indicated the resident's geri sleeves should have been applied as ordered.

Nurses' Notes, dated 8/20/21 at 11:53 a.m., indicated the resident had bruises to her left upper posterior arm that were light purple and green. Also, the left outer arm was purple and blue in color. No swelling was noted. The resident also had a skin tear to her left third finger. The Physician was notified and orders were obtained to monitor the bruising and skin tear until healed.

A Care Plan related to Aspirin therapy was also initiated on 8/20/21. 4. During an interview with Resident 37 on 8/16/21 at 11:57 a.m., he indicated he was upset about being charged for a medication that he did not receive. He had a rash on both of his arms that made him itch very badly. At that time, a red/purple bruise was noted to his left hand by his thumb. He indicated he probably bumped into something.

The record for Resident 37 was reviewed on 8/18/21 at 10:51 a.m. Diagnoses included, but were not limited to, stroke, peripheral vascular disease, abnormal coagulation, and

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	atherosclerotic heart disease of native coronary artery without angina pectoris. The Quarterly Minimum Data Set (MDS) assessment, dated 6/18/21, indicated the resident's short and long term memory was ok and he was independent for decision making. The resident received an anticoagulant medication in the last 7 days. A Care Plan, updated 6/2021, indicated the resident had a potential for complications related to anticoagulant therapy. Nursing approaches were to observe for signs of active bleeding (nosebleeds, bleeding gums, petechiae, purpura, ecchymotic areas, hematoma, blood in urine, blood in stools, and pain in joints. Nurses' Notes, dated 3/28/21 at 4:40 a.m., indicated "Resident reported intensive inching on bilateral lower and upper extremities, upper back and redness noted on private and buttocks area. Resident has no temp. House barrier cream applied to resident's affected area to relive itching. Voicemail left with physician for request." (sic) There was no documentation, assessment, or treatment obtained for the rash from 3/28-3/31/21. A Nurse Practitioner (NP) note, dated 3/31/21, indicated "Requested by wound care nurse to see patient for rash. Patient seen upright in wheelchair. Patient states he has rash to bilateral forearms, back, and perianal area. He reports that he has had rash for "a while". When asked patient to describe "a while". He states he has had the rash for "weeks". He states that the rash is highly pruritic and reports "sometimes when I scratch I swear it feels like I have something crawling under my skin". Patient admits to refusing showers or			

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	bathing because "I don't like to shower here. No one knows how to do it right". Last reported shower was back in 2020. He denies any change in clothing/diet and laundry is cleansed/performed at facility. Rash noted to bilateral forearms, isolated area to right shoulder blade. Unable to visualize rash to lower extremities due to chronic discoloration consistent with history of peripheral artery disease. Rash appears to be "pimple like" appearance pink/red coloring. His left arm is noted with 3 pimple like blisters that have been scratched distributed in a row. Patient started on hydroxyzine and topical steroid cream for management of itching. Patient has not been in and/or out of building. Per staff, patient has refused any type of bathing, including sponge bath." Physician's Orders, dated 3/31/21, indicated Hydroxyzine (an antihistamine) 25 milligrams (mg) give 1 tab every 6 hours as needed (prn) for itching. Physician's Orders, dated 4/1/21, indicated Hydrocortisone cream 2.5 % apply topically to affected areas where rash is four times a day as needed. The 4/2021 Medication Administration Record (MAR) indicated the resident did not receive any of the prn Hydrocortisone cream and he received Hydroxyzine 25 mg prn on 4/2 and 4/6/21. Nurses' Notes, dated 8/1-8/18/21, indicated there was no documentation regarding the bruise to hand by the thumb. Interview with the 4th Floor Unit Manager on 8/19/21 at 3:30 p.m., indicated there was no follow up assessment or documentation after the			

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	resident was identified with a rash. There was no treatment administered or ordered for the resident until 3/31/21. He was unaware the resident had a bruise to his right hand by his thumb. Nurses' Notes, dated 8/19/21 at 4:49 p.m., indicated the resident had a reddened are to the right hand between thumb and pointer finger. The area was blanchable and the resident denied any injury to his hand. Physician and family made aware. 5. On 8/16/21 at 9:20 a.m., Resident 102 was observed sitting in his wheelchair in his room watching television. At that time, a gauze bandage was observed to his left foot with a date of 8/13/21. Interview with the 5th floor Unit Manager at that time, indicated she had thought the treatment was every Monday, Wednesday and Friday. The record for Resident 102 was reviewed on 8/19/21 at 10:55 a.m. Diagnoses included, but were not limited to, stroke, osteomyelitis, peripheral vascular disease, peripheral artery disease, dementia without behavioral disturbance, high blood pressure, major depressive disorder, and dysphagia. The Quarterly Minimum Data Set (MDS) assessment, dated 8/4/21, indicated the resident was not alert and oriented, and he needed extensive assist with 1 person physical assist for dressing. A Care Plan, dated 5/27/21, indicated the resident had an arterial ulcer related to diabetes and arterial insufficiency. Physician's Orders, dated 8/12/21, indicated left			

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	first toe, cleanse with normal saline or wound cleanser, pat dry, apply iodosorb and cover with a dry dressing daily and prn. Physician's Orders, dated 8/6/21, indicated left heel, cleanse with normal saline pat dry and apply betadine and cover with a dry dressing daily. Wound notes, dated 6/24/21, indicated left heel arterial ulcer. The ulcer was last measured on 8/12/21 and was 0.5 centimeters (cm) by 0.8 cm. There was scabbing noted and the wound was stable. Wound notes, dated 5/27/21, indicated the left first toe arterial ulcer. The ulcer was last measured on 8/12/21 and was 1.4 cm by 1.9 cm. There was 20% of granulation tissue and 30% of eschar tissue noted. The wound was improving. The 8/2021 Medication Administration Record (MAR), indicated the treatment had been signed out as being completed on 8/14 and 8/15/21. Interview with the 5th floor Unit Manager on 8/17/21 at 2:12 p.m., indicated she thought the treatment was scheduled every Monday, Wednesday, and Friday. She was unaware when it had changed. The treatment was to be completed as ordered by the Physician.6. Resident 82 was observed in her bed on 8/18/21 at 9:06 a.m. Her left leg was edematous and there were no compression stockings in place to the leg. Interview with the resident at that time, indicated her left leg was swollen and nothing was being done about it. She indicated she had told several people about her leg. On 8/19/21 at 9:00 a.m., CNA 1 was observed providing morning care for the resident. When			

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	she was finished, the resident was dressed in her bed. She had no compression stockings in use and her feet were bare. The resident's record was reviewed on 8/18/21 at 9:10 a.m. Diagnoses included, but were not limited to, congestive heart failure and osteoarthritis. The Quarterly Minimum Data Set (MDS) assessment, dated 6/11/21, indicated the resident was cognitively intact and required extensive two person assistance for bed mobility and transfers. A Physician's Order, dated 8/17/21, indicated the resident was to have compression stockings applied in the morning and removed at night. The August 2021 Treatment Administration Record (TAR) did not have the order transferred to it. Interview with the 300 Unit Manager on 8/19/21 at 9:25 a.m., indicated the order had been entered incorrectly and had not been transferred to the TAR. She indicated the nurse who received the order should have initiated the compression stockings right away. 7. On 8/16/21 at 3:05 p.m., Resident 143 was observed in her bed. She had multiple open sores in various stages of healing on both arms and there were no dressings in place. On 8/17/21 at 3:12 p.m., the resident was in bed with no dressings on her arms. The resident's record was reviewed on 8/17/21 at 2:40 p.m. Diagnoses included, but were not limited to, iron deficiency anemia, weakness and diabetes mellitus.			

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	155131	A. BUILDING 00 B. WING	08/23/2021

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	The Quarterly Minimum Data Set (MDS) assessment, dated 6/1/21, indicated the resident had moderate cognitive impairment and needed extensive two person assistance for bed mobility. A Physician's Order, dated 8/9/21, indicated the resident was to have a Coban Self-Adherent Wrap (elastic bandage) applied to both arms on Monday and Thursday. A Physician's Order, dated 5/25/21, indicated the resident was to wear geri-sleeves (protective sleeves) at all times. Interview with LPN 1 on 8/17/21 at 3:30 p.m., indicated she had just repositioned the resident and she did not have any dressings on her arms. She indicated the resident would sometimes remove them. Interview with the 300 Unit Manager at that time, indicated the dressings should be reapplied if the resident removed them. 3.1-37(a)			
F 0687 SS=D Bldg. 00	483.25(b)(2)(i)(ii) Foot Care §483.25(b)(2) Foot care. To ensure that residents receive proper treatment and care to maintain mobility and good foot health, the facility must: (i) Provide foot care and treatment, in accordance with professional standards of practice, including to prevent complications from the resident's medical condition(s) and (ii) If necessary, assist the resident in making appointments with a qualified person, and			

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	arranging for transportation to and from such appointments. Based on observation, record review and interview, the facility failed to ensure dependent residents received foot care and had routine visits with a podiatrist related to long and thick toenails for 1 of 8 residents reviewed for ADL's. (Resident E) Finding includes: On 8/16/21 at 12:03 p.m., Resident E was observed in bed. His toenails were very long and thick. The resident's feet were dry and scaly. On 8/17/21 at 8:45 a.m. and 2:40 p.m., the resident was observed in bed. His toenails were very long and thick. The resident's feet were dry and scaly. On 8/18/21 at 8:50 a.m. and 10:45 a.m., the resident was observed in bed. His toenails were very long and thick. The resident's feet were dry and scaly. On 8/19/21 at 8:50 a.m., the resident was observed in bed. His toenails were very long and thick. The resident's feet were dry and scaly. The record for Resident E was reviewed on 8/17/21 at 3:00 p.m. Diagnoses included, but were not limited to, femur fracture, weakness, dysphagia, need for assistance with personal care, dementia, anxiety disorder, major depressive disorder, hearing loss, and legal blindness. The Quarterly Minimum Data Set (MDS) assessment, dated 7/4/21, indicated the resident was not alert and oriented and had short and long term memory problems. The resident was severely impaired for decision making. The resident was an extensive assist with 2 person physical assist for	F 0687	**Munster Med-Inn** **Annual Survey: 8/23/2021** Please accept the following as the facility's credible allegation of compliance. This plan of correction does not constitute an admission of guilt or liability by the facility and is submitted only in response to the regulatory requirement. **F687 Foot Care** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;** Resident E – Was added the podiatry schedule. **How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken;** All residents have the potential to be affected by the same alleged deficient practice. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur;** Staff were educated to notify the nurse and/or social services of any resident in need of foot care so that they may be added to the podiatry schedule.	09/03/2021

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	transfers, and totally dependent on staff with 1 assist for toileting and personal hygiene. The last documented podiatry note was dated 10/2/20. The progress note indicated the resident had fungal nails on all of his toes. The resident's nails were discolored yellow and his feet were dry and scaly. His nails were debrided and it was recommended the resident be seen every 61 days for preventative nail care. It was also recommended a topical fungal cream be applied to the feet daily. Interview with the 4th floor Unit Manager on 8/19/21 at 8:52 a.m., indicated the podiatrist was in the facility last month, however, did not see the resident. The resident's toenails were very long, discolored and thick. 3.1-47(a)(7)		**How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance programs will be put into place;** Social Service Director/designee will audit weekly to ensure that new admissions as well as residents with need for foot care are added to the podiatry schedule accordingly. Social Service Director/designee will present a summary of the audits to the Quality Assurance committee monthly for 6 months. Thereafter, if determined by the Quality Assurance committee, auditing and monitoring will be done quarterly and present quarterly at the QA meeting. Monitoring will be on going. **Date by which systemic corrections will be completed: 9/3/2021**	
F 0688 SS=D Bldg. 00	483.25(c)(1)-(3) Increase/Prevent Decrease in ROM/Mobility §483.25(c) Mobility. §483.25(c)(1) The facility must ensure that a resident who enters the facility without limited range of motion does not experience reduction in range of motion unless the resident's clinical condition demonstrates that a reduction in range of motion is unavoidable; and §483.25(c)(2) A resident with limited range of motion receives appropriate treatment and			

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	services to increase range of motion and/or to prevent further decrease in range of motion. §483.25(c)(3) A resident with limited mobility receives appropriate services, equipment, and assistance to maintain or improve mobility with the maximum practicable independence unless a reduction in mobility is demonstrably unavoidable. Based on observation, record review and interview, the facility failed to ensure arm positioning devices were in place as ordered for 1 of 1 residents reviewed for positioning. (Resident 6) Finding includes: On 8/17/21 at 10:48 a.m., Resident 6 was observed in bed. She did not have a sling on her right arm. On 8/18/21 at 11:40 a.m., the resident was observed in bed without a sling on her right arm. The resident's record was reviewed on 8/18/21 at 11:00 a.m. Diagnoses included, but were not limited to, right shaft humerus (upper arm) fracture with routine healing and weakness. The Quarterly Minimum Data Set (MDS) assessment, dated 6/17/21, indicated the resident was cognitively intact and needed extensive one person assistance for bed mobility and dressing. A Physician's Order, dated 1/23/21, indicated the resident was to wear a sling to her right arm at all times. The August 2021 Treatment Administration Record (TAR), indicated the sling had been signed off as applied on 8/16, and was blank on	F 0688	**Munster Med-Inn** **Annual Survey: 8/23/2021** Please accept the following as the facility's credible allegation of compliance. This plan of correction does not constitute an admission of guilt or liability by the facility and is submitted only in response to the regulatory requirement. **F688 Increase/Prevent Decrease in ROM/Mobility** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:** Resident -6 orthopedic physician was made aware of residents' refusal to wear arm sling. Follow up appointment was made and responsible party was notified. **How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken;** All residents with adaptive equipment have the potential to be	09/03/2021

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	8/17 and 8/18/21. Interview with the resident on 8/18/21 at 11:40 a.m., indicated the sling was never applied anymore, she did not know where it was. She indicated she had limited range of motion with her right arm and was unable to move it in an up and down motion. Interview with Nurse Consultant 1 on 8/18/21 at 11:58 a.m., indicated she did not know why the treatment was not completed as ordered. 3.1-42(a)(2)		affected by the alleged deficient practice. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:** Nurses were in-serviced on ensuring adaptive equipment/devices are in place as per orders. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance programs will be put into place;** Unit managers will audit 2 residents with adaptive equipment/devices, 2 times a week to ensure they are in place as ordered. The Director of Nursing/designee will present a summary of the audits to the Quality Assurance committee monthly for 6 months. Thereafter, if determined by the Quality Assurance committee, auditing and monitoring will be done quarterly and present quarterly at the QA meeting. Monitoring will be on going. **Date by which systemic corrections will be completed: 9/3/2021**	
F 0689 SS=D Bldg. 00	483.25(d)(1)(2) Free of Accident Hazards/Supervision/Devices			

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	§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 observation, record review, and interview, the facility failed to ensure each resident received adequate supervision related to swallowing precautions for 1 of 3 residents reviewed for accidents/hazards. (Resident E) Finding includes: On 8/16/21 at 12:03 p.m., CNA 2 was observed positioning Resident E in bed so he could eat his lunch. The CNA raised the head of the bed and gave the resident a container of apple juice with a straw so he could drink. The resident drank the entire cup of juice. The CNA fed him 3 large bites of mashed potatoes then 1 sip of water. The resident was taking long sips of liquid. She then gave him 2 large bites of ground meat and mashed potatoes. He started to cough, so she gave him water to drink through the straw. He took a long sip of water and started coughing again. She gave him another sip of water to clear his throat. She fed him 4 large bites of mashed potatoes and ground meat mixed together and then a sip of water. The CNA opened the ice cream and fed him 5 large spoonfuls of ice cream, and then a sip of water. She fed him another 5 large bites of ice cream and then offered water through the straw. She gave him 2 more large bites of ice cream and then tried the dessert which was sliced pairs with granola. She gave him 2 large bites of the pear dessert and then offered water. The resident did	F 0689	**Munster Med-Inn** **Annual Survey: 8/23/2021** Please accept the following as the facility's credible allegation of compliance. This plan of correction does not constitute an admission of guilt or liability by the facility and is submitted only in response to the regulatory requirement. **F689 Free of Accident Hazards/Supervision/Devices** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;** Resident E was immediately provided assistance with swallowing precautions and care plan was updated. CNA 2- was re-educated on following swallowing precautions when providing feeding assistance. **How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be**	09/03/2021

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	not swallow the pear so she gave him more water to drink. He still had the pear in his mouth but would not spit it out. She gave him a bite of mashed potatoes and all of his food was swallowed that was in his mouth. The resident indicated he was finished, so the CNA put the head of the bed down flat and picked up his tray and left the room. Interview with CNA 2 at that time, indicated the swallowing precautions were noted above his bed and all staff were to follow them. On 8/19/21 at 12:10 p.m., the resident was sitting up in his wheelchair, and being fed by CNA 2. She was observed feeding the resident 2 to 3 large to medium bites of food and offering him a drink. Interview with the CNA 2 at that time, indicated the resident liked to drink a lot fluids at one time. She indicated she was told she could give a couple of bites of food then offer the drink. The record for Resident E was reviewed on 8/17/21 at 3:00 p.m. Diagnoses included, but were not limited to, femur fracture, weakness, dysphagia, need for assistance with personal care, dementia, anxiety disorder, major depressive disorder, hearing loss, and legal blindness. The Quarterly Minimum Data Set (MDS) assessment, dated 7/4/21, indicated the resident was not alert and oriented and had short and long term memory problems. The resident was severely impaired for decision making. The resident needed limited assist with 1 person physical assist for eating. Speech therapy notes, dated 6/7/21, indicated the resident required supervision during meals. The		**taken;** All residents who have orders for swallowing precautions have the potential to be affected by the same alleged deficient practice. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur;** Staff were in-serviced on how to identify residents requiring swallowing precautions and to ensure precautions are provided per orders. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance programs will be put into place;** Nurse Managers will randomly audit 5 residents with swallowing precautions weekly on alternating units and meals to ensure swallowing precautions are followed per orders. The Director of Nursing/designee will present a summary of the audits to the Quality Assurance committee monthly for 6 months. Thereafter, if determined by the Quality Assurance committee, auditing and monitoring will be done quarterly and present quarterly at the QA meeting. Monitoring will be on going. **Date by which systemic corrections will be completed:**	

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	recommendations were mechanical soft textures and ground meat. The swallowing strategies were recommended for oral intake: upright posture during meals and upright posture for greater than 30 minutes after meals. Provide oral care before/after meals, slowly alternate small sips, bites, observe for pocketing between presentations and at the end of meals, clear residue with finger/toothette sweep and/or liquid wash, ensure food was moistened, minimize distractions, controlled/single straw sips. There was no Care Plan related to the swallowing guidelines. Interview with the 4th Floor Unit Manager on 8/20/21 at 3:30 p.m., indicated the CNA was to follow the Speech therapist recommendations while feeding the resident. 3.1-45(a)(2)		**9/3/2021**	
F 0692 SS=E Bldg. 00	483.25(g)(1)-(3) Nutrition/Hydration Status Maintenance §483.25(g) Assisted nutrition and hydration. (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(1) Maintains acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrates that this is not possible or resident preferences indicate otherwise;			

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	§483.25(g)(2) Is offered sufficient fluid intake to maintain proper hydration and health; §483.25(g)(3) Is offered a therapeutic diet when there is a nutritional problem and the health care provider orders a therapeutic diet. Based on record review and interview, the facility failed to ensure residents maintained acceptable parameters of nutritional status related to meal consumption records not completed, Registered Dietitian's (RD) recommendations for tube flushes not followed as well as fluid restrictions not followed as ordered for residents who were nutritionally at risk for 4 of 4 residents reviewed for nutrition. (Residents 15, 102, 174, and 73) Findings include: 1. The record for Resident 15 was reviewed on 8/19/21 at 9:15 a.m. Diagnoses included, but were not limited to, traumatic subdural hemorrhage with loss of consciousness, major depressive disorder, dementia with behavioral disturbance, atrial fibrillation, heart failure, high blood pressure, repeated falls, stroke, and type 2 diabetes. The Quarterly Minimum Data Set (MDS) assessment, dated 7/8/21, indicated the resident was not alert and oriented. She needed supervision with set up for eating and weighed 158 pounds with a weight gain. The resident received a therapeutic diet and had no oral problems. A Care Plan, dated 2/23/21, indicated the resident required a therapeutic diet related to heart failure. The nursing approaches were to monitor fluid and food consumption.	F 0692	**Munster Med-Inn** **Annual Survey: 8/23/2021** Please accept the following as the facility's credible allegation of compliance. This plan of correction does not constitute an admission of guilt or liability by the facility and is submitted only in response to the regulatory requirement. **F692 Nutrition/Hydration Status Maintenance** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;** Resident 15- Fluid and food consumption were updated. Resident 102- Food Consumption was updated. Resident 174- RD recommendations were reviewed and orders for water flush were clarified. Resident 73- Fluid consumption is being documented due to fluid restriction. **How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be**	09/03/2021

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	The weight log indicated the resident weighed 156 pounds on 7/8/21 and on 8/3/21 weighed 143 pounds which was a 8.3% weight loss in 1 month. An RD note, dated 8/12/21, addressed the resident's current weight and indicated it was probably due to diuretic use. The meal consumption logs for 7/2021 and 8/2021, indicated the breakfast meal was not documented on 7/3, 7/4, 7/10, 7/14, 7/17, 7/18, 7/19, 7/20, 7/23, 7/25, 7/26, 7/27, 7/28, 7/30, 7/31, 8/1, 8/11, 8/14, 8/17, and 8/18/21. The lunch meal was not documented on 7/3, 7/4, 7/10, 7/14, 7/17, 7/18, 7/19, 7/20, 7/22, 7/23, 7/25, 7/26, 7/27, 7/28, 7/30, 7/31, 8/1, 8/11, 8/14, 8/17, and 8/18/21. The dinner meal was not documented on 7/3, 7/4, 7/12, 7/14, 7/18, 7/19, 7/20, 7/22, 7/23, 7/26, 7/27, 7/31, 8/4, 8/11, 8/14, and 8/16/21. Interview with the 5th floor Unit Manager on 8/20/21 at 2:20 p.m., indicated meal consumption logs were to be completed for all three meals. 2. The record for Resident 102 was reviewed on 8/19/21 at 10:55 a.m. Diagnoses included, but were not limited to, stroke, osteomyelitis, peripheral vascular disease, peripheral artery disease, dementia without behavioral disturbance, high blood pressure, major depressive disorder, and dysphagia. The Quarterly Minimum Data Set (MDS) assessment, dated 8/4/21, indicated the resident was not alert and oriented, and needed extensive assist with 1 person physical assist for dressing. The resident needed supervision with set up for eating and had no oral problems. The resident received a mechanically altered and therapeutic		**taken;** All residents have the potential to be affected by the same alleged deficient practice. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur;** Nursing staff was in-serviced on documenting meal intake in point of care. Nursing staff were in-serviced on documenting fluid intake for residents on fluid restrictions. Nursing staff was in-serviced on following up with RD recommendations in a timely manner. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance programs will be put into place;** Nurse Managers will audit meal intake documentation for 10 residents in Point of Care 2 times per week to ensure documentation compliance. Nurse Managers will audit 3 residents with fluid restrictions 2 times per week to ensure compliance with intake documentation. Director of Nursing/designee will randomly audit 5 residents dietary recommendations weekly to ensure dietary recommendations were completed and completed	

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	diet and weighed 135 pounds with a significant weight gain. The Care Plan, dated 1/4/21, indicated the resident required a mechanically altered diet related to dysphagia. The nursing approaches were to monitor and record intake of food. The weight record indicated the resident weighed 155 pounds on 2/5/21 and 135 pounds on 8/3/21 which was a 12.90 % weight loss in the last 6 months. A RD note, dated 8/4/21, indicated the weight loss was addressed and identified. The meal consumption logs for 7/2021 and 8/2021, indicated the breakfast meal was not documented on 7/3, 7/4, 7/14, 7/17, 7/18, 7/19, 7/20, 7/25, 7/26, 7/27, 7/28, 7/30, 7/31, 8/1, 8/11, 8/14, 8/17, and 8/18/21. The lunch was not documented on 7/3, 7/4, 7/9, 7/14, 7/17, 7/18, 7/19, 7/20, 7/22, 7/25, 7/26, 7/27, 7/28, 7/30, 7/31, 8/1, 8/11, 8/14, 8/17, and 8/18/21. The dinner was not documented on 7/3, 7/4, 7/8, 7/11, 7/14, 7/18, 7/19, 7/22, 7/27, 8/4, and 8/11/21. Interview with the 5th Floor Unit Manager on 8/20/21 at 2:20 p.m., indicated meal consumption logs were to be completed for all three meals. 3. The record for Resident 174 was reviewed on 8/18/21 at 12:20 p.m. Diagnoses included, but were not limited to, heart failure, stroke, dysphagia, high blood pressure, contractures of both hands, dementia, moderate protein-calorie malnutrition, gastrostomy, and dependence on supplemental oxygen. The Quarterly Minimum Data Set (MDS)		timely. The Director of Nursing/designee will present a summary of the audits to the Quality Assurance committee monthly for 6 months. Thereafter, if determined by the Quality Assurance committee, auditing and monitoring will be done quarterly and present quarterly at the QA meeting. Monitoring will be on going. **Date by which systemic corrections will be completed: 9/3/2021**	

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	155131	A. BUILDING 00 B. WING	08/23/2021

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	assessment, dated 7/21/21, indicated the resident was not alert and oriented and was totally dependent on staff with 1 person physical help with personal hygiene. The resident weighed 124 pounds with a significant weight loss noted. She was dependent on enteral feedings and received 51% or greater of all nutrition through the peg tube. The resident had received oxygen while a resident. A Care Plan, dated 1/20/21, indicated the resident was dependent on tube feedings for total nutrition and hydration support. The nursing approaches were water flushes as ordered and dietitian to evaluate adequacy and appropriateness of current feeding in relation to resident's condition and nutrient needs. The resident weighed 139 pounds on 2/2/21 and 120 pounds on 8/4/21 which was a 13.67% loss in 6 months. A RD note, dated 7/8/21, indicated a recommendation to flush the peg tube with 250 milliliters (ml) of water three times a day. Physician's Orders, dated 7/7/21, indicated flush peg tube with 225 cubic centimeters (cc) of water every 6 hours. The order was discontinued on 7/21/21. Physician's Orders, dated 7/21/21, indicated flush peg tube with 250 cc every 6 hours every shift. A RD note, dated 8/5/21, indicated a recommendation to flush the peg tube with 300 ml three times a day for 900 ml of water daily. Physician's Orders, dated 8/10/21, indicated to flush the peg tube with 300 ml of water every shift.			

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	Interview with the 4th floor Unit Manager on 8/19/21 at 3:30 p.m., indicated the RD recommendations were not acted on timely. The current and undated, "Diet Recommendation" policy, provided by the Director of Nursing on 8/20/21 at 2:00 p.m., indicated the dietitian or designee would follow up on routine recommendations within 10 days and urgent recommendations within 24 to 72 hours. The recommendations by the dietitian would be addressed in a "timely manner" and per regulatory requirements.4. On 8/16/21 at 9:17 a.m., Resident 73 indicated sometimes she would ask for water and the staff would forget to bring it to her. There were no fluids observed at her bedside. The resident's record was reviewed on 8/17/21 at 3:03 p.m. Diagnoses included, but were not limited to, chronic respiratory failure and chronic obstructive pulmonary disease. The Physician's Order Summary, dated 8/2021, indicated the resident was on a fluid restriction of 1500 cc (cubic centimeters) per 24 hours. The fluids were broken down into each shift between dietary and nursing. Nursing: 11-7 shift 123 cc, 7-3 shift 240 cc, and 3-11 shift 240 cc. Dietary: breakfast 417 cc, lunch 240 cc, and dinner 240 cc. The fluid intakes documented in the computer, dated 8/14/21-8/17/21, had not been completed for some shifts and did not include the total of the fluids consumed in 24 hours. The 8/2021 Medication Administration Record lacked documentation of the fluids consumed or monitoring of the fluid restriction. A Care Plan, updated 8/4/21, indicated the			

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	resident required a 1500 cc fluid restriction daily. The interventions included, "...monitor intake of meals...prepare/serve diet and fluid restriction as ordered..." Interview with LPN 7 on 8/18/21 at 8:53 a.m., indicated the resident was not on a strict fluid restriction. The Nurses were allowed to give out a certain amount of fluids each shift. The CNAs documented the fluids consumed during the meals in the computer. Interview with CNA 7 on 8/18/21 at 8:54 a.m., indicated the resident was on a fluid restriction. She would document the amount the resident drank during meals in the computer. Interview with the 2nd floor Unit Manager on 8/18/21 at 10:15 a.m., indicated the Nurses and CNAs should all have been documenting the amount of fluids the resident consumed in the computer so they could see the total amount of fluids the resident was consuming daily. 3.1-46(a)(1)			
F 0693 SS=D Bldg. 00	483.25(g)(4)(5) Tube Feeding Mgmt/Restore Eating Skills §483.25(g)(4)-(5) Enteral Nutrition (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(4) A resident who has been able to eat enough alone or with assistance is not fed by enteral methods unless the resident's clinical condition demonstrates that enteral			

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	feeding was clinically indicated and consented to by the resident; and §483.25(g)(5) A resident who is fed by enteral means receives the appropriate treatment and services to restore, if possible, oral eating skills and to prevent complications of enteral feeding including but not limited to aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers. Based on observation, record review and interview, the facility failed to ensure tube feeding medications and flushes were instilled via gravity and medications were crushed and administered separately and not all together for 1 of 5 residents observed for medication administration. (Resident 174) Finding includes: On 8/20/21 at 9:30 a.m., LPN 3 was observed preparing and pouring medications for Resident 174. She poured Metoprolol (a blood pressure medication) 25 milligrams (mg) 1 tablet, Irbesartan (a blood pressure medication) 150 mg 1 tablet and Doxazosin (a blood pressure medication)1 mg 1 tablet all into a medication cup. She finished pouring 8 other medications and placed them all in a separate medication cup. She walked into the resident's room and took her blood pressure and checked for placement of the peg tube (a tube inserted directly into the stomach for nutrition) with a stethoscope and air bolus. After she was finished, she came back to the cart and crushed all the blood pressure medications together and left them in the cup and then crushed the other 8 medications together and left them in the cup. She picked up the 2 medication cups and walked back into the resident's room. She obtained water	F 0693	**Munster Med-Inn** **Annual Survey: 08/23/21** Please accept the following as the facility's credible allegation of compliance. This plan of correction does not constitute an admission of guilt or liability by the facility and is submitted only in response to the regulatory requirement. **F693 Tube Feeding Management/Restore Eating Skills** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;** Resident 174 was immediately assessed and noted with no adverse reactions to medications given via g-tube. LPN 3- was re-inserviced regarding medication administration via g-tube. **How the facility will identify other residents having the potential to be affected by the**	09/03/2021

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	from the faucet and filled the container. She then diluted both medication cups with 10 cubic centimeters (cc) of water. She inserted the plunger into the container of water and drew up 10 cc of water. She opened the peg tube and placed the plunger directly into the tube and pushed the water down the tube. She removed the syringe and plunger and placed the syringe back into the peg tube. She administered the blood pressure medications first and then immediately followed with the 8 other medications. She did not flush with any water in between the medications. She then put the plunger back into the syringe and pushed the medications down the tube. She removed the plunger and poured 20 cc of water into the syringe and administered per gravity. The record for Resident 174 was reviewed on 8/18/21 at 12:20 p.m. Diagnoses included, but were not limited to, heart failure, stroke, dysphagia, high blood pressure, contractures of both hands, dementia, moderate protein-calorie malnutrition, gastrostomy, and dependence on supplemental oxygen. The Quarterly Minimum Data Set (MDS) assessment, dated 7/21/21, indicated the resident was not alert and oriented and was totally dependent on staff with 1 person physical help with personal hygiene. The resident weighed 124 pounds with a significant weight loss noted. She was dependent on enteral feedings and received 51% or greater of all nutrition through the peg tube. The resident had received oxygen while a resident. Interview with the Director of Nursing on 8/23/21 at 10:15 a.m., indicated the medications were to be administered 1 at a time and all medications and the water flushes were to be administered to		**same deficient practice and what corrective action will be taken;** All residents with g-tubes have the potential to be affected by the same alleged deficient practice. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur;** Clinical staff were re-educated on proper medication administration technique for residents with g-tubes including medications should be instilled via gravity and medications are to be crushed and administered separately. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance programs will be put into place;** Nurse manager will randomly audit/observe 2 nurse's administer medications via feeding tube 2 times per week to ensure proper medication administration technique. DON/designee will present a summary of the audits to the Quality Assurance committee monthly for 6 months. Thereafter, if determined by the Quality Assurance committee, auditing and monitoring will be done quarterly and present quarterly at the QA meeting. Monitoring will be on going.	

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	gravity and not pushed through the peg tube. The current and 10/25/2014 "Enteral Tube Medication Administration" policy, provided by the Director of Nursing (DON) on 8/23/21 at 10:15 a.m., indicated put 15 to 30 ml of water in syringe and flush tubing using gravity flow. Pour dissolved/diluted medication into the syringe and unclamp tubing. allowing medication to flow to gravity. 3.1-44(a)(2)		**Date by which systemic corrections will be completed: 9/3/2021**	
F 0695 SS=E Bldg. 00	483.25(i) Respiratory/Tracheostomy Care and Suctioning § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. Based on observation, record review and interview, the facility failed to ensure oxygen was applied at the correct flow rate and per Physician's Orders. The facility also failed to ensure oxygen tubing was dated and humidification bottles were not stored on the floor for 5 of 6 residents reviewed for oxygen. (Residents 51, 174, 173, 59, and 73) Findings include: 1. On 8/16/21 at 1:15 p.m. and 3:00 p.m., Resident 51 was observed with oxygen in use by the way of a nasal cannula. The oxygen concentrator was set	F 0695	**Munster Med-Inn** **Annual Survey: 8/23/2021** Please accept the following as the facility's credible allegation of compliance. This plan of correction does not constitute an admission of guilt or liability by the facility and is submitted only in response to the regulatory requirement. **F695 Respiratory** **What corrective action(s) will be accomplished for those**	09/03/2021

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	at 0.5 liters. On 8/17/21 at 9:15 a.m. and 10:47 a.m., the resident's oxygen concentrator was set at 0.5 liters. The resident was wearing her oxygen at that time. On 8/20/21 at 9:27 a.m., the resident's oxygen concentrator was set at 2 liters. The resident was wearing her oxygen at that time. The record for Resident 51 was reviewed on 8/20/21 at 10:58 a.m. Diagnoses included, but were not limited to, dementia with behavior disturbance, chronic pulmonary edema, and oxygen dependent. The Quarterly Minimum Data Set (MDS) assessment, dated 7/29/21, indicated the resident was cognitively impaired and she had received oxygen during the assessment reference period. A Care Plan, dated 9/17/20 and reviewed on 8/20/21, indicated the resident required oxygen therapy prn (as needed) to relieve hypoxia (low oxygen levels) related to severe pulmonary hypertension. Interventions included, but were not limited to, administer oxygen as ordered. A Physician's Order, dated 4/16/21, indicated the resident was to receive oxygen by the way of a nasal cannula at 2 liters per minute as needed (prn) for an oxygen saturation of less than 92%. The resident's oxygen saturation was to be monitored every shift. The 8/2021 Medication Administration Record (MAR), indicated the resident's oxygen saturation level was greater than 92% on the day shift 8/16-8/20/21. The prn oxygen had not been		**residents found to have been affected by the deficient practice;** The oxygen flow rate was corrected, oxygen tubing labeled, and humidification bottle replaced for residents 73, 59, 51 174, and 173. **How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken;** All residents receiving oxygen have the potential to be affected by the same alleged deficient practice. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur;** Staff were re-educated on oxygen care with focus on: oxygen administered at the correct flow rate as per order, ensuring oxygen tubing is changed and labeled appropriately, and no tubing/humidification is touching the floor. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance programs will be put into place;** Facility Angels/designee will audit 15 residents 3 times per week to ensure oxygen tubing is dated,	

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	signed out for the entire month of August. Interview with the MCU Unit Manager on 8/20/21 at 10:30 a.m., indicated even though the oxygen order was prn, the resident's family wanted her to wear the oxygen. She indicated she would contact the Physician. She also indicated the concentrator should have been set at 2 liters instead of 0.5 liters. 2. On 8/16/21 at 2:50 p.m., Resident 174 was observed in bed. At that time, she was wearing oxygen per nasal cannula with pads behind her ears. The oxygen flow rate was set at 2.5 liters per minute. On 8/17/21 at 9:13 a.m., the resident was observed in bed. At that time, she was wearing oxygen per nasal cannula with pads behind her ears. The oxygen flow rate was set at 2.5 liters per minute. On 8/17/21 at 2:37 p.m., the resident was observed in bed. At that time she was wearing oxygen per nasal cannula. The pads were down around her chin and not behind her ears. The oxygen flow rate was set at 2.5 liters per minute. On 8/18/21 at 1:50 p.m., the resident was observed sitting up in her geri recliner in her room. At that time, she was wearing oxygen per nasal cannula and the pads were not behind her ears but down by her chin area. The oxygen was set at 2.5 liters. The 4th floor Unit Manager adjusted the oxygen to 2 liters per minute. The record for Resident 174 was reviewed on 8/18/21 at 12:20 p.m. Diagnoses included, but were not limited to, heart failure, stroke, dysphagia, high blood pressure, contractures of both hands, dementia, moderate protein-calorie malnutrition, gastrostomy, and dependence on supplemental oxygen.		oxygen is set at the correct flow rate, and tubing/humidification aren't touching the floor. Director of Nursing/designee will present a summary of the audits to the Quality Assurance committee monthly for 6 months. Thereafter, if determined by the Quality Assurance committee, auditing and monitoring will be done quarterly and present quarterly at the QA meeting. Monitoring will be on going. **Date by which systemic corrections will be completed: 9/3/2021**	

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	The Quarterly Minimum Data Set (MDS) assessment, dated 7/21/21, indicated the resident was not alert and oriented and was totally dependent on staff with 1 person physical help with personal hygiene. The resident weighed 124 pounds with a significant weight loss noted. She was dependent on enteral feedings and received 51% or greater of all nutrition through the peg tube. The resident had received oxygen while a resident. A Care Plan, dated 1/27/21, indicated the resident required oxygen therapy. The approaches were to administer oxygen as ordered. Physician's Orders, dated 8/4/21, indicated oxygen at 2 liters nasal cannula and use ear pad for continuous oxygen. Interview with the 4th floor Unit Manager on 8/18/21 at 1:50 p.m., indicated the resident's oxygen was to be set at 2 liters and the ear pads were to be behind her ears.3. On 8/16/21 at 9:15 a.m., Resident 173 was observed in her bed with her oxygen on via nasal cannula. The nasal cannula tubing was dated 8/8/21. On 8/18/21 at 1:50 p.m., the nasal cannula tubing was dated 8/8/21. The resident's record was reviewed on 8/18/21 at 2:30 p.m. Diagnoses included, but were not limited to, chronic bronchitis. A Physician's Order, dated 4/1/21, indicated the oxygen tubing was to be changed every Sunday. The August 2021 Medication Administration Record (MAR), indicated the tubing had been			

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	changed on Sunday 8/15. However, the tubing was currently dated the prior week of 8/8/21. Interview with Nurse Consultant 1 on 8/18/21 at 2:11 p.m., indicated she was unaware the oxygen tubing had not been changed.4. On 8/16/21 at 2:49 p.m., Resident 59 was observed lying in bed. Her oxygen nasal cannula was in place and the concentrator was set at 2.5 liters/minute. The water bottle attached to the concentrator for humidification was resting on the floor. On 8/18/21 at 10:17 a.m., Resident 59 was observed lying in bed. Her oxygen nasal cannula was in place and the concentrator was set at 3 liters/minute. The water bottle attached to the concentrator for humidification was resting on the floor. The resident's record was reviewed on 8/18/21 at 1:21 p.m. Diagnoses included, but were not limited to, chronic respiratory failure and chronic obstructive pulmonary disease. A Physician's Order, dated 6/8/21, indicated oxygen via nasal cannula, continuous at 2 liters/minute. Interview with the 3rd floor Unit Manager on 8/18/21 at 11:46 a.m., indicated someone had probably knocked the humidification bottle off the concentrator, she would take care of it. 5. On 8/16/21 at 9:21 a.m., Resident 73's oxygen was in place and the concentrator was set at 3.5 liters/minute. The oxygen tubing was dated 7/19/21. On 8/17/21 at 2:59 p.m., Resident 73 was observed lying in bed. The oxygen concentrator was set at			

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	3.5 liters/minute and the tubing was dated 7/19/21. The resident's record was reviewed on 8/17/21 at 3:03 p.m. Diagnoses included, but were not limited to, chronic respiratory failure and chronic obstructive pulmonary disease. The Physician's Order Summary, dated 8/2021, indicated oxygen per nasal cannula at 3 liters/minute and to change tubing and mask weekly. Interview and observation with LPN 7 on 8/18/21 at 11:46 a.m., indicated the resident's oxygen was set at 3.5 liters/minute and should have been at 3 liters/minute. The oxygen tubing was now dated 8/15/21. 3.1-47(a)(6)			
F 0697 SS=D Bldg. 00	483.25(k) Pain Management §483.25(k) Pain Management. The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. Based on record review and interview, the facility failed to ensure pain medication was provided as ordered for 1 of 4 residents reviewed for pain. (Resident 82) Finding includes: Resident 82's record was reviewed on 8/18/21 at 9:10 a.m. Diagnoses included, but were not limited to, chronic pain syndrome and osteoarthritis.	F 0697	**Munster Med-Inn** **Annual Survey: 8/23/2021** Please accept the following as the facility's credible allegation of compliance. This plan of correction does not constitute an admission of guilt or liability by the facility and is submitted only in response to the regulatory requirement.	09/03/2021

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
MUNSTER MED-INN	7935 CALUMET AVE MUNSTER, IN 46321

(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
	The Quarterly Minimum Data Set (MDS) assessment, dated 6/11/21, indicated the resident was cognitively intact. A Physician's Order, dated 3/30/21, indicated the resident was to have Voltaren gel 1% (a topical analgesic) applied four times daily to both knees for pain. The August 2021 Treatment Administration Record (TAR), indicated the Voltaren gel had not been signed out since 9:00 p.m. on 8/13/21. The TAR indicated the resident had refused the Voltaren gel on 8/16/21 at 5:00 p.m. and 9:00 p.m. Interview with LPN 1 on 8/18/21 at 2:35 p.m., indicated the Wound Nurse was responsible for applying the Voltaren gel and she had not given it to the resident. Interview with Wound Nurse 1 on 8/18/21 at 2:36 p.m., indicated it was the floor nurse's responsibility to apply the Voltaren gel. LPN 1 then indicated she was an agency nurse and she did not know it was her responsibility. 3.1-37(a)		**F697 Pain Management** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;** Pain medication was administered as per orders for resident 82. **How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken;** All facility residents that require pain management have the potential to be affected by the same alleged deficient practice. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur;** Nurses were re-educated on administering medications as per orders. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance programs will be put into place;** Nurse Manager will randomly audit 5 residents' medication administration record 2 times per week to ensure mediations are provided as per orders. Director of Nursing/designee will present a summary of the audits to the Quality Assurance	

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			committee monthly for 6 months. Thereafter, if determined by the Quality Assurance committee, auditing and monitoring will be done quarterly and present quarterly at the QA meeting. Monitoring will be on going. **Date by which systemic corrections will be completed: 9/3/2021**	
F 0759 SS=D Bldg. 00	483.45(f)(1) Free of Medication Error Rts 5 Prcnt or More §483.45(f) Medication Errors. The facility must ensure that its- §483.45(f)(1) Medication error rates are not 5 percent or greater; Based on observation, record review, and interview, the facility failed to ensure a medication error rate of less than 5% for 2 of 5 residents observed during medication pass. Two errors were observed during 27 opportunities for errors during medication administration. This resulted in a medication error rate of 7.41%. (Residents 174 and F) Findings include: 1. On 8/20/21 at 9:30 a.m., LPN 3 was observed preparing and pouring medication for Resident 174. She poured Metoprolol (a blood pressure medication) 25 milligrams (mg) 1 tablet, Irbesartan (a blood pressure medication) 150 mg 1 tablet and Doxazosin (a blood pressure medication)1 mg 1 tablet all into a medication cup. She finished pouring 8 other medications and placed them all in a separate medication cup. She walked into the resident's room and took her blood pressure and	F 0759	**Munster Med-Inn** **Annual Survey: 8/23/2021** Please accept the following as the facility's credible allegation of compliance. This plan of correction does not constitute an admission of guilt or liability by the facility and is submitted only in response to the regulatory requirement. **F759 Free of Medication Error Rate of 5% or More** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;** Resident F and 174 were assessed and noted with no adverse reactions to medication.	09/03/2021

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	checked for placement of the peg tube (a tube inserted directly into the stomach for nutrition) with a stethoscope and air bolus. After she was finished, she came back to the cart and crushed all the blood pressure medications together and left them in the cup and then crushed the other 8 medications together and left them in the cup. She picked up the 2 medication cups and walked back into the resident's room. She obtained water from the faucet and filled the container. She then diluted both medication cups with 10 cubic centimeters (cc) of water. She inserted the plunger into the container of water and drew up 10 cc of water. She opened the peg tube and placed the plunger directly into the tube and plunged the water down the tube. She removed the syringe and plunger and placed the syringe back into the peg tube. She administered the blood pressure medications first and then immediately followed with the 8 other medications. She did not flush with any water in between the medications. She then put the plunger back into the syringe and plunged the medications down the tube. She removed the plunger and poured 20 cc of water into the syringe and administered per gravity. The record for Resident 174 was reviewed on 8/18/21 at 12:20 p.m. Diagnoses included, but were not limited to, heart failure, stroke, dysphagia, high blood pressure, contractures of both hands, dementia, moderate protein-calorie malnutrition, gastrostomy, and dependence on supplemental oxygen. The Quarterly Minimum Data Set (MDS) assessment, dated 7/21/21, indicated the resident was not alert and oriented and was totally dependent on staff with 1 person physical help with personal hygiene. The resident weighed 124 pounds with a significant weight loss noted. She		LPN 2 and LPN 3- were re-educated on both g-tube and use of insulin pens **How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken;** All residents have the potential to be affected by the same alleged deficient practice. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur;** Licensed nurses were educated on medication administration including: Use of insulin pens and priming insulin pens G-tube administration separate cups for each medication, flushing with 5-10ml of water between each medication. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance programs will be put into place;** Nurse managers will observe/audit 2 nurses administer insulin 2 time per week to ensure proper administration technique. Nurse manager will randomly audit/observe 2 nurse administer medications via feeding tube 2 times per week to ensure proper	

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	was dependent on enteral feedings and received 51% or greater of all nutrition through the peg tube. The resident had received oxygen while a resident. Interview with the Director of Nursing on 8/23/21 at 10:15 a.m., indicated a water flush was to be completed between the medication administration. The current and 10/25/2014 "Enteral Tube Medication Administration" policy, provided by the Director of Nursing (DON) on 8/23/21 at 10:15 a.m., indicated flush with 5 to 10 milliliters (ml) of warm water between each medication. If administering more than 1 medication flush with 5 to 10 ml of water or prescribed amount between each medication or per physician's order." 2. During medication administration observation on 8/20/21 at 12:20 p.m., LPN 2 was observed preparing an insulin injection for Resident F. The resident's blood sugar was obtained prior to and was 237 which indicated he was to receive 4 units of Novolog insulin. The LPN removed an insulin flex pen from the medication cart. She dialed the pen to 4 units, cleaned the top of the pen with an alcohol wipe and attached the needle. She performed hand hygiene and donned clean gloves to both hands. She wiped the resident's arm with an alcohol pad and let it dry. She placed the insulin pen on his arm and administered the 4 units of insulin. She did not prime the pen prior to administration. The record for Resident F was reviewed on 8/23/21 at 1:05 p.m. Diagnoses included, but were not limited to, diabetes. Physician's Orders, dated 6/22/21, indicated "Novolog Flexpen U-100 Insulin per sliding scale		medication administration technique. DON/designee will present a summary of the audits to the Quality Assurance committee monthly for 6 months. Thereafter, if determined by the Quality Assurance committee, auditing and monitoring will be done quarterly and present quarterly at the QA meeting. Monitoring will be on going. **Date by which systemic corrections will be completed: 9/3/2021**	

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	If blood sugar is less than 60 and greater than 430 call doctor. If blood sugar is 181-230, give 2 units, If BS (blood sugar) is 231-280, give 4 units, If blood sugar is 281-330, give 6 units, If BS is 331-380, give 8 units, If BS is 381-430, give 10 units, if BS is greater than 430, give 12 units, and call physician." Interview with the LPN at that time, indicated she was unaware she needed to prime the insulin pen prior to use. The manufacturer's recommendations from the Novolog flexpen indicated giving an airshot before each injection: "Turn the dose selector to select 2 units. Hold your Novolog Flexpen with the needle pointing up. Tap the cartridge gently with your finger a few times to make any air bubbles collect at the top of the cartridge. Keep the needle pointing upwards, press the push-button all the way in until the dose selector returns to 0. A drop of insulin should appear at the needle tip." Interview with the Director of Nursing on 8/23/21 at 10:15 a.m., indicated the insulin flexpen needed to be primed prior to use. 3.1-48(c)(1)			
F 0761 SS=D Bldg. 00	483.45(g)(h)(1)(2) Label/Store Drugs and Biologicals §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.			

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	§483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. Based on observation, record review and interview, the facility failed to ensure liquid antiseptics were not stored at the bedside for 2 of 2 random observations. (Resident 140) Finding includes: On 8/16/21 at 11:56 a.m., a bottle of hydrogen peroxide and a bottle of rubbing alcohol were observed on Resident 140's bedside table. On 8/18/21 at 10:43 a.m., the hydrogen peroxide and the rubbing alcohol were again observed on the resident's bedside table. The record for Resident 140 was reviewed on 8/18/21 at 11:00 a.m. Diagnoses included, but were not limited to, high blood pressure and edema. The Quarterly Minimum Data Set (MDS)	F 0761	**Munster Med-Inn** **Annual Survey: 8/23/2021** Please accept the following as the facility's credible allegation of compliance. This plan of correction does not constitute an admission of guilt or liability by the facility and is submitted only in response to the regulatory requirement. **F761 Label/Storage Drugs & Biologicals** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;** Resident 140- Hydrogen peroxide and alcohol were immediately secured and stored appropriately.	09/03/2021

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	assessment, dated 7/27/21, indicated the resident was cognitively intact for daily decision making. Interview with the Second Floor Unit Manager on 8/18/21 at 10:45 a.m., indicated the resident had been told he could not have the hydrogen peroxide and the rubbing alcohol in his room. She indicated the items shouldn't have been in the resident's room. 3.1-25(m)		**How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken;** All residents have the potential to be affected by the same alleged deficient practice. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur;** Staff were re-educated to ensure that no over the counter items including liquid antiseptic are not stored at the bedside. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance programs will be put into place;** Facility angels will audit 15 residents 3 times per week to ensure no medications are left unattended or at the bedside. Director of Nursing/designee will present a summary of the audits to the Quality Assurance committee monthly for 6 months. Thereafter, if determined by the Quality Assurance committee, auditing and monitoring will be done quarterly and present quarterly at the QA meeting. Monitoring will be on going.	

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F 0921 SS=E Bldg. 00	483.90(i) Safe/Functional/Sanitary/Comfortable Environ §483.90(i) Other Environmental Conditions The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. Based on observation and interview, the facility failed to ensure the residents' environment was clean and in good repair related to dusty ceiling vents, chipped paint, marred walls, dirty and torn floor mats, dirty toilet bowls and sinks, and leaking sinks for 4 of 5 units. (The Second, Third, Fourth, and Fifth floors) Findings include: During the Environmental Tour with the Administrator and Maintenance Supervisor on 8/23/21 at 11:48 a.m., the following was observed: 1. The Second Floor a. The black cushion on the right side of the toilet riser arm in the bathroom of Room 203 was discolored with a white substance. Two residents shared the bathroom. b. The bathroom sink in Room 229 was leaking. A garbage can was observed under the sink and it was half full of water. One resident used this bathroom. 2. The Third Floor a. The pillow for bed 2 in Room 319 was observed to be cracked and no pillow case was in use. The	F 0921	**Munster Med-Inn** **Annual Survey: 8/23/2021** Please accept the following as the facility's credible allegation of compliance. This plan of correction does not constitute an admission of guilt or liability by the facility and is submitted only in response to the regulatory requirement. **F921** **Safe/Functional/Sanitary/Comfortable Environment** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;** Black cushion on toilet riser in 203 was removed, leaking sink in room 229 was repaired, pillows in room 319 were replaced and low air loss mattresses cleaned, the ceiling vent in room 422 was cleaned and rust cleaned from the toilet bowel, Ceiling vent was cleaned in room 503, The night stand and wall were repaired in room 511 and the floor mats were replaced, room 502's	09/03/2021

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	low air loss mattress was also dirty. Two residents resided in this room. 3. The Fourth Floor a. The ceiling vent in the bathroom of Room 422 had an accumulation of dust. There were also rust rings in the toilet. One resident used this bathroom. 4. The Fifth Floor a. A large accumulation of dust was observed on the bathroom ceiling vent in Room 503. Four residents shared the bathroom. b. The wall behind bed 1 in Room 511 was scratched and marred. The night stand was also scratched and marred. The floor mats next to bed 1 were dirty and torn. Two residents resided in the room. c. The wall behind bed 2 in Room 502 was scratched and marred. The edge of the wall next to the closet was scratched and marred. The ceiling vent in the bathroom had an accumulation of dust. Two residents resided in the room and shared the bathroom. d. The base of the wall across from bed 2 in Room 516 had areas of chipped paint. A large accumulation of dust was observed on the ceiling vent in the bathroom. Two residents resided in the room and four residents shared the bathroom. Interview with the Administrator at that time, indicated all of the above were in need of cleaning and/or repair. 3.1-19(f)		wall was repaired and ceiling vents cleaned, chipped paint in room 516 was repaired and ceiling vents in bathroom cleaned. **How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken;** All residents have the potential to be affected by the same alleged deficient practice. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur;** Staff were re-educated on the procedure of notifying maintenance/environmental services of any necessary repairs/cleaning needed. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance programs will be put into place;** Environmental services supervisor/designee will audit 10 rooms per week on alternating floors for Environmental/cleaning issues. Any identified issues will be corrected. Maintenance supervisor/ designee will audit 10 rooms per week on alternating floors for Maintenance issues. Any identified issues will be corrected.	

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			Administrator/designee will present a summary of the audits to the Quality Assurance committee monthly for 6 months. Thereafter, if determined by the Quality Assurance committee, auditing and monitoring will be done quarterly and present quarterly at the QA meeting. Monitoring will be on going. **Date by which systemic corrections will be completed: 9/3/2021**	