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	11/20/2023

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

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F 0000 Bldg. 00	This visit was for a Recertification and State Licensure Survey. This visit included the Investigation of Complaints IN00418486, IN00419836, IN00420482, and IN00420643. Complaint IN00418486 - Federal/state deficiencies related to the allegations are cited at F684 and F687. Complaint IN00419836 - Federal/state deficiencies related to the allegations are cited at F677. Complaint IN00420482 - No deficiencies related to the allegations are cited. Complaint IN00420643 - Federal/state deficiencies related to the allegations are cited at F684, F686, and F921. Survey dates: November 14, 15, 16, 17, and 20, 2023. Facility number: 000056 Provider number: 155131 AIM number: 100289450 Census Bed Type: SNF/NF: 157 Total: 157 Census Payor Type: Medicare: 14 Medicaid: 126 Other: 17 Total: 157 These deficiencies reflect State Findings cited in	F 0000	The Facility respectfully asks for a desk review.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
shanika willhite	Administrator	12/14/2023

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determin other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclo days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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	accordance with 410 IAC 16.2-3.1. Quality review completed on 11/27/23.			
F 0554 SS=D Bldg. 00	483.10(c)(7) Resident Self-Admin Meds-Clinically Approp §483.10(c)(7) The right to self-administer medications if the interdisciplinary team, as defined by §483.21(b)(2)(ii), has determined that this practice is clinically appropriate. Based on observation, record review, and interview, the facility failed to ensure residents had Physician's Orders for medications and an assessment to self-administer their own medications for 1 of 1 residents reviewed for self-administration of medication. (Resident 146) Finding includes: On 11/16/23 at 3:10 p.m., Resident 146's room was observed. At that time, there was a box of Ivizia eye drops on the over bed table. The resident was not in her room. On 11/17/23 at 7:46 a.m., the resident was observed in bed eating breakfast. At that time, there was a box of Ivizia eye drops on the over bed table. The resident indicated she put the eye drops in her eyes when she needed them. The record for Resident 146 was reviewed on 11/16/23 at 1:25 p.m. Diagnoses included, but were not limited to, hypertensive chronic kidney disease, type 2 diabetes, end stage renal disease, dependence on renal dialysis, acute kidney failure, repeated falls, and edema. The 9/6/23 Quarterly Minimum Data Set (MDS) assessment indicated the resident was cognitively intact. The resident's vision was adequate with a	F 0554	**Munster Med INN** **Annual Survey: 11/20/2023** 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. **F554 Resident Self Admin Meds-Clinically Appropriate** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;** A self-administration of medication assessment was completed for resident 146. The physician was notified, and orders were obtained for Ivizia eye drops and for resident to self-administer eye drops. **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;**	12/04/2023

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	corrective lens. She had no oral problems, weighed 122 pounds, and has had a significant weight loss. The resident received dialysis as a resident. There was no Physician's Order for the Ivizia eye drops, nor was there a self-administration assessment for the resident to administer her own eye drops. Interview with the Second Floor Unit Manager (UM) on 11/17/23 at 8:45 a.m., indicated she was unaware the resident had eye drops in her room. Interview with the Second Floor UM on 11/17/23 at 3:20 p.m., indicated she asked the resident where she got the eye drops from and she told her at the eye doctor. She used the eye drops when she needed them for her dry eyes. The UM called the eye doctor and asked about the eye drops and they indicated they did give them to her and they were to be used as needed for dry eyes. The current 9/1/2020 "Medication Storage" policy, provided by the Assistant Director of Nursing on 11/17/23 at 3:23 p.m., indicated the facility should not administer bed side medications without a Physician's Order. The medications should be stored in a locked compartment within the resident's room. 3.1-11(a)		All facility residents with medication orders 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 on not leaving medications at resident bedside unless there is an order for self-administration and a self-administration assessment completed. **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 Angel’s will audit 10 residents 3 days per week to ensure no medication is improperly stored at the bedside and any medication noted at bedside has orders for self-administration. The Director of Nursing/designee will present a summary of the audits to the Quality Assurance committee monthly for 4 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**	

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			corrections will be completed: 12/4/2023	
F 0656 SS=D Bldg. 00	483.21(b)(1)(3) Develop/Implement Comprehensive Care Plan §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for			

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	future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. §483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (iii) Be culturally-competent and trauma-informed.			
	Based on record review and interview, the facility failed to initiate Care Plans related to pressure ulcers and medication use for 2 of 33 residents whose Care Plans were reviewed. (Residents N and 12) Findings include: 1. The record for Resident N was reviewed on 11/16/23 at 2:23 p.m. Diagnoses included, but were not limited to, palliative care, dementia with behavior disturbance, and peripheral vascular disease (PVD). The Quarterly Minimum Data Set (MDS) assessment, dated 8/15/23, indicated the resident was moderately impaired for daily decision making. The resident required extensive assistance for bed mobility. The "Wound Rounds" Progress Notes indicated the resident had the following wounds present: - 10/30/23 Unstageable (full-thickness pressure injuries in which the base was obscured by slough and/or eschar) pressure ulcer to the right posterior upper thigh.	F 0656	**Munster Med-Inn** **Annual Survey: 11/20/2023** 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. **F656 Develop/Implement Comprehensive Care Plan** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;** Resident 12's – care plan was implemented related to antidepressant, antipsychotic, and anticoagulant medications. Resident N's – Care plan was implemented related to pressure ulcers. **How the facility will identify**	12/04/2023

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	- 10/31/23 Stage 2 (open wound) pressure ulcer to the left posterior upper thigh. - 11/10/23 Deep Tissue Injury (purple or maroon localized area of discolored intact skin or blood filled blister) to the right heel. - 11/10/23 Deep Tissue Injury to the left upper buttock. The current Care Plan did not address the resident's pressure ulcers. Interview with the Assistant Director of Nursing (ADON) on 11/17/23 at 3:00 p.m., indicated the resident's pressure ulcers should have been addressed on the current Care Plan. 2. The record for Resident 12 was reviewed on 11/16/23 at 9:37 a.m. The resident was admitted to the facility on 7/26/23 from the hospital. Diagnoses included, but were not limited to, type 2 diabetes, Parkinson's disease, stroke, dementia with other behavioral disturbance, urinary tract infections, obstructive uropathy, chronic kidney disease, and major depressive disorder. The Quarterly Minimum Data Set (MDS) assessment, dated 10/9/23, indicated the resident was moderately impaired for decision making and had no behaviors. The resident had an indwelling foley catheter and received antipsychotic, antidepressant, and antiplatelet medications. There were no Care Plans for the antipsychotic, antidepressant, and antiplatelet medications. Physician's Orders, dated 10/10/23, indicated Trazodone (an antidepressant medication) 150 milligrams (mg) daily, aspirin (an antiplatelet		**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 staff were re-educated on completing care plans for residents related to medications and skin conditions timely. **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 randomly audit 10 residents weekly to ensure care plans are in place. With a special focus on anticoagulant, antipsychotics, antidepressant, and pressure ulcer care plans. MDS/designee will present a summary of the audits to the Quality Assurance committee monthly for 4 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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	medication) 81 mg one time a day, and Olanzapine (an antipsychotic medication) 5 mg at bedtime. Interview with the Second Floor Unit Manager on 11/17/23 at 8:40 a.m., indicated she was unaware the resident's Care Plans were not completed as the MDS department was responsible for those. Interview with the Assistant Director of Nursing on 11/17/23 at 10:00 a.m., indicated the medications on the MDS assessments should have had a Care Plan. 3.1-35(a)		**Date by which systemic corrections will be completed: 12/4/2023**	
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 activities of daily living (ADL's) related to nail care and shaving for 4 of 13 residents reviewed for ADL's. (Residents E, G, F, and B) Findings include: 1. On 11/15/23 at 10:15 a.m., Resident E was observed in their room in bed. A brown substance was observed underneath their fingernails on both hands. At 2:45 p.m., the resident was dressed and seated in his wheelchair in their room. The brown substance remained underneath their fingernails. On 11/16/23 at 9:22 a.m., 11:28 a.m., and 1:58 p.m.,	F 0677	**Munster Med INN** **Annual Survey: 11/20/2023** 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;**	12/04/2023

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	the brown substance remained underneath the resident's fingernails The record for Resident E was reviewed on 11/16/23 at 9:51 a.m. Diagnoses included, but were not limited to, stroke, dementia with other behavior disturbance, major depressive disorder, and chronic kidney disease Stage 3. The Quarterly Minimum Data Set (MDS) assessment, dated 9/11/23, indicated the resident was moderately impaired for daily decision making, required moderate assistance with personal hygiene, and was dependent on staff for bathing. The resident had received a complete bed bath on 11/4, 11/6, 11/7, 11/8, 11/12, 11/13, and 11/15/23. A partial bed bath was given on 11/10 and 11/14/23. Nail care was documented as being completed on 11/4, 11/6, 11/8, 11/9, 11/12, and 11/13/23. Nail care was also documented as being completed on 11/15/23 at 10:08 a.m. Interview with the Assistant Director of Nursing on 11/17/23 at 2:03 p.m., indicated the resident's nails should have been cleaned during care. 2. On 11/14/23 1:52 p.m., on 11/15/23 at 10:48 a.m. and 3:15 p.m., on 11/16/23 at 9:15 a.m. and 1:50 p.m., and on 11/17/23 at 8:04 a.m. and 9:33 a.m., Resident G was observed in bed. At those times the resident had long gray facial hair under their chin. The record for Resident G was reviewed on 11/15/23 at 3:32 p.m. Diagnoses included, but were not limited to, multiple sclerosis, vascular		Assistance with grooming including nail care and shaving was provided to residents E, G, B, and F. **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 dependent residents with assistance with Activities of Daily Living (ADL's) including 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 Angel's will Audit 10 residents weekly, to ensure assistance with ADL's is being provided with a special focus on shaving and nail care. Director of Nursing/designee will present a summary of the audits to the Quality Assurance committee monthly for 4 months. Thereafter, if determined by the Quality Assurance committee,	

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	dementia, major depressive disorder, mood disorder, paraplegia, hammer toes for left and right feet, right foot deformity, pain in the toes, fecal impaction, constipation, and anxiety. The 9/14/23 Quarterly Minimum Data Set (MDS) assessment, indicated the resident was severely impaired for decision making and had short and long term memory problems. The resident needed extensive assist with 2 person physical assist for bed mobility and toileting, and an extensive assist with a 1 person physical assist for personal hygiene, dressing and eating. The resident was frequently incontinent of bowel and was not on a bowel toileting program. A Care Plan, revised on 9/1/23, indicated the resident had deficits in self care. The approaches were provide assistance to the extent needed for mobility, dressing, eating, toileting, personal hygiene, oral care and bathing. There was no documentation the resident rejected or refused care for personal hygiene. The task documentation indicated the resident received a completed bed bath on 11/9, 11/10, 11/11, 11/12, and 11/14/23. Interview with the Second Floor Unit Manager on 11/17/23 at 8:40 a.m., indicated the resident does not refuse care and their facial hair should have been removed.3. On 11/15/23 at 10:36 a.m., Resident F was observed with long dirty fingernails. The resident indicated they had been cut "once." On 11/16/23 at 10:24 a.m., the resident's fingernails were long and dirty and their shirt had food		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: 12/4/2023**	

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crumbs and stains on it.

Resident F's record was reviewed on 11/15/23 at 11:03 a.m. Diagnoses included, but were not limited to, dementia, Parkinson's , anemia, hypertension (high blood pressure), seizure disorder, malnutrition, and insomnia (difficulty sleeping).

The Quarterly Minimum Data Set (MDS) assessment, dated 9/19/23, indicated the resident was moderately impaired for daily decision making. The resident required partial/moderate assistance with toileting, upper and lower body dressing, and bathing. Oral hygiene required supervision or touching and eating required set up/clean up.

A Care Plan, dated 9/19/23, indicated the resident had a self care deficit with ADLs including bed mobility, eating, transfers, and toileting. Interventions included, but were not limited to, assist with bed mobility, eating, transfers, and toileting as needed.

A Nurse's Note, dated 9/19/23 at 9:04 a.m., indicated the resident required assistance with ADLs related to Parkinson's disease.

Nail care was last provided on 10/20/23.

Interview with the Assistant Director of Nursing (ADON) on 11/17/23 at 1:44 p.m., indicated the resident needed their nails cut.

4. On 11/15/23 at 2:38 p.m., Resident B was observed with several light gray whiskers on their chin.

On 11/16/23 at 10:56 a.m., Resident B was

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	observed laying in bed, and the whiskers were still present on the chin. The resident expressed they didn't like them. Resident B's record was reviewed on 11/17/23 at 3:39 p.m. Diagnoses included, but were not limited to, dementia, heart failure, hypertension (high blood pressure), anxiety and depression. The Quarterly Minimum Data Set (MDS) assessment, dated 10/3/23, indicated the resident was cognitively intact for daily decision making and had no upper and lower body limitations and used a wheelchair. A Care Plan, dated 11/1/23, indicated the resident had a self care performance deficit with ADLs including bed mobility, eating, transfers, and toileting. Interventions included, but were not limited to, assist with bed mobility, eating, transfers, and toileting as needed. Interview with the Assistant Director of Nursing (ADON) on 11/17/23 at 9:35 a.m., indicated she had no further information to provide. This citation relates to Complaint IN00419836. 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 facility must ensure that residents receive treatment and care in accordance with			

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	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 ensure areas of bruising and scabbing were assessed and monitored and lotion was applied to dry scaly feet for 8 of 9 residents reviewed for skin conditions non-pressure related. The facility also failed to ensure residents were monitored for constipation for 1 of 1 resident reviewed for constipation. (Residents N, E, K, C, G, M, J, and H) Findings include: 1. On 11/15/23 at 10:26 a.m. and 3:00 p.m., Resident N was observed in their room in bed. A fading purple bruise was observed on the top of their left hand. On 11/16/23 at 9:26 a.m. and 11:28 a.m., the bruising remained to the resident's left hand. The record for Resident N was reviewed on 11/16/23 at 2:23 p.m. Diagnoses included, but were not limited to, palliative care, dementia with behavior disturbance, and peripheral vascular disease (PVD). The Quarterly Minimum Data Set (MDS) assessment, dated 8/15/23, indicated the resident was moderately impaired for daily decision making. The resident required extensive assistance for bed mobility. There was no Care Plan related to the resident's bruise. The Weekly Skin Observation form, dated 11/14/23, indicated the resident's skin was intact.	F 0684	**Munster Med-Inn** **Annual Survey: 11/20/2023** 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's M, K, N, H, and E- Bruises were assessed, MD was notified. New orders were obtained to monitor bruising. Resident G- New orders were received to prevent future constipation. Resident J'-s scabbed area was addressed. Resident's -C dry skin was addressed. **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**	12/04/2023

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	There was no documentation about the resident's bruise. Interview with the Assistant Director of Nursing on 11/17/23 at 2:03 p.m., indicated there was no additional documentation related to the resident's bruising. 2. On 11/14/23 at 2:13 p.m., Resident E was observed in their room in bed and was wearing a hospital gown. Large areas of reddish/purple bruising were observed to their bilateral forearms and hands. The resident was not wearing geri sleeves (protective arm coverings) at that time. On 11/15/23 at 2:45 p.m., the resident was observed in their room seated in his wheelchair. The resident was dressed and geri sleeves were in use. The record for Resident E was reviewed on 11/16/23 at 9:51 a.m. Diagnoses included, but were not limited to, stroke, dementia with other behavior disturbance, major depressive disorder, and chronic kidney disease Stage 3. The resident did not have a diagnosis of purpura (a rash of purple spots due to small blood vessels leaking blood into the skin). The Quarterly Minimum Data Set (MDS) assessment, dated 9/11/23, indicated the resident was moderately impaired for daily decision making, required extensive assistance with bed mobility and moderate assistance with transfers. A Care Plan, dated 6/26/23 and reviewed on 9/11/23, indicated the resident was at risk for complications related to anticoagulant therapy use. Interventions included, but were not limited to, daily skin inspection per facility protocol and		**place or what systemic changes will be made to ensure that the deficient practice does not recur;** Nurses were re-educated on: Addressing and assessing changes in skin condition such as bruises, obtaining orders for treatment, and implementation of treatment. Assistive clinical staff were educated on: Notifying the nurse of any change in residents' skin conditions. **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 10 residents 3 times per week to ensure areas of bruising, dry skin, or scabbed areas are reported to the nurse. Nurse Managers will review 10 residents Point of Care (POC) documentation weekly to ensure residents with no bowel movement for 3 days or more are provided an intervention for constipation. Director of Nursing/designee will present a summary of the audits to the Quality Assurance committee monthly for 4 months. Thereafter, if determined by the Quality Assurance committee, auditing and monitoring will be	

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	report abnormalities to the nurse. Observe/document/report as needed (PRN) adverse reactions of antiplatelet therapy: blood tinged or red blood in urine, black tarry stools, dark or bright red blood in stools, sudden severe headaches, nausea, vomiting, diarrhea, muscle joint pain, lethargy, bruising, blurred vision, shortness of breath, loss of appetite, sudden changes in mental status, and significant or sudden changes in vital signs. A Physician's Order, dated 11/1/23, indicated the resident was to receive Plavix (an antiplatelet medication) 75 milligrams (mg) one time a day. A Physician's Order, dated 11/15/23, indicated the resident was to wear geri sleeves or long sleeves at all times for skin protection. The geri sleeves could be removed for hygiene. The Weekly Skin Observation form, dated 11/9/23, indicated the resident's skin was intact and no concerns were noted. Interview with the Assistant Director of Nursing (ADON) on 11/17/23 at 2:30 p.m., indicated the resident's bruises should have been monitored. 3. On 11/14/23 at 10:39 a.m., Resident K was observed in their room in bed. A fading green bruise was observed on the left hand. On 11/17/23 at 9:44 a.m., the fading green bruise remained to Resident K's left hand. The record for Resident K was reviewed on 11/17/23 at 9:49 a.m. Diagnoses included, but were not limited to, muscle weakness, malaise, history of lung cancer, bed confinement, and reduced mobility. The resident was admitted to		done quarterly and present quarterly at the QA meeting. Monitoring will be on going. **Date by which systemic corrections will be completed: 12/4/2023**	

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the facility on 11/9/23.

The Admission Minimum Data Set (MDS) assessment was in progress.

The Admission Nursing assessment, dated 11/9/23, did not identify the bruising to the left hand.

A Physician's Order, dated 11/10/23, indicated the resident's skin was to be assessed weekly on Tuesday and Friday evening.

The 11/2023 Medication Administration Record (MAR), indicated the skin assessments were signed out as being completed on 11/10 and 11/14/23. There was no documentation indicating the resident had any bruises.

Interview with the Assistant Director of Nursing on 11/17/23 at 3:05 p.m., indicated the area of bruising to the resident's left hand was not assessed and monitored.

4. On 11/14/23 at 11:23 a.m., Resident C was observed in their room in bed. The resident's feet were exposed and elevated on a blanket. The resident was observed with dry, scaly skin to the soles of both feet and along the arch. Interview with the resident at that time, indicated on occasion staff would put lotion on their feet and legs.

On 11/15/23 at 10:30 a.m., the resident was again observed with dry, scaly skin to her feet.

On 11/16/23 at 9:28 a.m., 11:30 a.m., and 1:54 p.m., the resident's feet remained dry and scaly.

The record for Resident C was reviewed on

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	11/16/23 at 11:03 a.m. Diagnoses included, but were not limited to, hemiplegia and hemiparesis (muscle weakness and paralysis) following a stroke, type 2 diabetes, and epilepsy. The Quarterly Minimum Data Set (MDS) assessment, dated 8/16/23, indicated the resident was cognitively intact and required extensive assistance with personal hygiene. The resident had no current order to apply lotion to their feet. The Weekly Skin Observation form, dated 11/15/23, indicated the resident's skin was intact. There was no documentation related to the resident's scaly feet. Interview with the Assistant Director of Nursing (ADON) on 11/20/23 at 1:00 p.m., indicated lotion should have been applied to the resident's feet. 5. On 11/14/23 1:52 p.m., on 11/15/23 at 10:48 a.m. and 3:15 p.m., on 11/16/23 at 9:15 a.m. and 1:50 p.m., and on 11/17/23 at 8:04 a.m. and 9:33 a.m., Resident G was observed in bed. At those times the resident had long thick toenails with dry scaly skin on both feet. The record for Resident G was reviewed on 11/15/23 at 3:32 p.m. Diagnoses included, but were not limited to, multiple sclerosis, vascular dementia, major depressive disorder, mood disorder, paraplegia, hammer toes for left and right feet, right foot deformity, pain in the toes, fecal impaction, constipation, and anxiety. The 9/14/23 Quarterly Minimum Data Set (MDS) assessment, indicated the resident was severely impaired for decision making and had short and long term memory problems. The resident needed			

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extensive assist with 2 person physical assist for bed mobility and toileting, and an extensive assist with a 1 person physical assist for personal hygiene, dressing and eating. The resident was frequently incontinent of bowel and was not on a bowel toileting program.

A Care Plan, revised on 6/30/23, indicated the resident had impaired skin integrity to the right outer ankle. The approaches were to render treatment as per orders.

A Care Plan, initiated on 9/1/23, indicated the resident was at risk for constipation related to immobility. The approaches were to implement the bowel regimen if no bowel movement every 3 days.

There were no Physician's Orders for any type of lotion for the resident's dry scaly skin on their feet.

A Nurses' Note, dated 8/27/23 at 1:26 a.m., indicated at 12:45 a.m., the resident was observed to be lethargic. Their name was called but they did not open their eyes. The resident's blood pressure was 148/84, temperature was 101.2, and the pulse was 101. The Physician was notified and new orders to send the resident to the emergency room was obtained. The resident left the facility at 1:20 a.m.

The History and Physical from the hospital, dated 8/27/23, indicated the assessment of the resident was cholelithiasis (gallstones) with possible cholecystitis (an inflamed gallbladder), abdominal pain, and high grade constipation with massive fecal impaction of sigmoid colon.

A Cat Scan (CT) of the pelvis without contrast,

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dated 8/27/23, indicated high grade constipation with massive fecal impaction of the sigmoid colon in the rectum.

The resident returned to the facility on 8/31/23.

Physician's Orders, dated 6/9/23, indicated Docusate Sodium 50 milligrams/5 milliliters (ml), give 5 ml two times a day. Polyethylene glycol powder 17 grams every morning for constipation and Lactulose 10 grams/15 ml, give 30 ml at bedtime for constipation.

Physician's Orders, dated 8/31/23, indicated Senokot S oral tablet 8.6-50 milligrams (mg) (a stimulant laxative), give 2 tablets via the peg tube every 24 hours as needed for constipation.

The Bowel Movement (BM) Record indicated the resident had a small BM on 8/22, 2 small BM's on 8/23, no BM on 8/24 and 8/25 and 1 small BM on 8/26/23.

The BM Record indicated the resident had no BM on 9/8, 9/9, and 9/10/23. There was no BM recorded on 10/5, 10/6, 10/7, 10/29, 10/30, 10/31, and 11/1/23.

The Medication Administration Record (MAR) for the months of 9/2023,10/2023 and 11/1-11/16/23, indicated the medication of Senokot S oral tablet 8.6-50 mg as needed for constipation had not been administered.

Interview with the Second Floor Unit Manager (UM) on 11/17/23 at 8:45 a.m., indicated the resident had a long history of constipation and after 3 days something should be done if there was no bowel movement. She was unaware the resident's feet were dry and scaly.

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Interview with the UM on 11/17/23 at 3:20 p.m., indicated she put in an order for an extra dose of Lactulose for the resident. She indicated after 3 days of no bowel movement, the "as needed" medication should have been used.

The current 9/20/21, "Bowel Elimination Protocol" policy, provided by the Assistant Director of Nursing on 11/17/23 at 3:23 p.m., indicated residents who had no BM for 72 hours will be considered for pharmacological intervention or non-pharmacological intervention, such as prune juice, or encourage increased fluids. It should be taken into consideration that some residents may have a "normal" bowel pattern of greater than 72 hours without constipation. Each resident should be considered on an individual basis.

6. During an interview with Resident M on 11/14/23 at 11:47 a.m., the resident indicated there was a bruise to their right outer hand. At that time, they removed the geri sleeve and the red/purple bruised area was observed.

The record for Resident M was reviewed on 11/16/23 at 11:03 a.m. Diagnoses included, but were not limited to, COPD (chronic obstructive pulmonary disease), anemia, chronic respiratory failure, major depressive disorder, high blood pressure, anxiety, and dependence on supplemental oxygen.

The 9/29/23 Quarterly Minimum Data Set (MDS) assessment, indicated the resident was cognitively intact. The resident received oxygen as a resident and in the last 7 days and an anticoagulant medication.

The Care Plan, revised on 6/13/23, indicated the

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resident had potential/ actual impairment to skin integrity related to the use and side effects of the anticoagulant medication. The approaches were to document weekly skin observations.

Physician's Orders, dated 5/10/23, indicated geri sleeves or long sleeves to be worn at all times for skin protection.

Physician's Orders, dated 5/20/23, indicated Eliquis (an anticoagulant medication) 2.5 milligrams (mg) two times a day.

The last weekly skin observation was dated 11/10/23 at 1:15 p.m. and there were no bruises or any other skin concerns indicated.

There was no documentation in Nurses' Notes from 10/20-11/15/23 regarding any bruising to their right hand area.

Interview with the Second Floor Unit Manager (UM) on 11/17/23 at 8:45 a.m., indicated she was unaware the resident had a bruise to the right hand.

Interview with the UM on 11/17/23 at 3:20 p.m., indicated the area was new and she asked the resident how they got it and the resident indicated it was from bumping the side rail while in bed.

7. On 11/14/23 at 10:45 a.m., Resident J was observed sitting up in a wheelchair by the Nurses' Station. At that time, there were 2 large scabbed areas on the resident's face. One scab was located above the left eye and the other was on the right side of the cheek.

The record for Resident J was reviewed on 11/16/23 at 3:03 p.m.. Diagnoses included, but

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	were not limited to, stroke, Alzheimer's disease, pressure ulcer of the sacral region, psychotic disorder, major depressive disorder, and osteoarthritis. The 10/22/23 Modification of the Quarterly Minimum Data Set (MDS) assessment, indicated the resident was rarely understood/understands and was severely impaired for decision making. The resident had 1 stage 3 pressure ulcer. A Care Plan, revised on 11/15/23, indicated the resident was at risk for complications related to impaired skin integrity. The approaches were to evaluate the skin and skin integrity. The last Weekly Skin Assessment, completed on 11/15/23, indicated there was no skin breakdown. There was no documentation regarding the scabbed areas on the right cheek and above the left eye. There was no documentation in Nursing Progress Notes from 10/20/23 through 11/16/23 regarding the scabbed areas to the face. Interview with the Second Floor Unit Manager (UM) on 11/17/23 at 8:40 a.m., indicated she had thought the scabbed areas were from their glasses, however there was no documentation in the record to reflect that. Interview with the Second Floor UM on 11/17/23 at 3:20 p.m., indicated there was no documentation or an assessment completed of the scabbed areas to the resident's face. The UN indicated they have been there for so long, however, nothing was documented.8. On 11/14/23 at 10:25 a.m., a reddish/ burgundy discoloration was observed on Resident H's bilateral forearms.			

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On 11/16/23 at 10:25 a.m., the fading discoloration remained to the resident's bilateral forearms.

The record for Resident H was reviewed on 11/16/23 at 9:30 a.m. Diagnoses included, but were not limited to, chronic obstructive pulmonary disease, hypertension, and type 2 diabetes.

The Quarterly Minimum Data Set (MDS) assessment, dated 8/26/23, indicated the resident had cognitive impairment. The resident needed extensive assistance with bed mobility and transfers.

The Weekly Skin Observation sheet, dated 11/14/23, indicated the resident's skin was intact and there was no documentation of bruising.

Interview with the Assistant Director of Nursing (ADON) on 11/20/23 at 2:53 p.m., indicated she reported the resident's bilateral forearm bruising to the nurse and there was now an order for the bruising to be monitored.

A policy titled "Skin Condition Assessment & Monitoring Pressure and Non-Pressure" received as current from the Assistant Director of Nursing (ADON) on 11/17/23 at 3:23 p.m., indicated: "...Non- pressure skin conditions (bruises/contusions, abrasions, lacerations, rashes, skin tears, surgical wounds, etc.) Will be assessed for healing progress and signs of complications or infection weekly...."

This citation relates to Complaints IN00418486 and IN00420643.

3.1-37(a)

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F 0685 SS=D Bldg. 00	483.25(a)(1)(2) Treatment/Devices to Maintain Hearing/Vision §483.25(a) Vision and hearing To ensure that residents receive proper treatment and assistive devices to maintain vision and hearing abilities, the facility must, if necessary, assist the resident- §483.25(a)(1) In making appointments, and §483.25(a)(2) By arranging for transportation to and from the office of a practitioner specializing in the treatment of vision or hearing impairment or the office of a professional specializing in the provision of vision or hearing assistive devices.			
	Based on record review and interview, the facility failed to ensure an Optometrist's recommendation for eye drops was completed in a timely manner for 1 of 4 residents reviewed for communication and sensory. (Resident 146) Finding includes: During an interview on 11/14/23 at 2:49 p.m., Resident 146 indicated she had seen the eye doctor and thought new glasses were ordered, but she had not received them. The record for Resident 146 was reviewed on 11/16/23 at 1:25 p.m. Diagnoses included, but were not limited to, hypertensive chronic kidney disease, type 2 diabetes, end stage renal disease, dependence on renal dialysis, acute kidney failure, repeated falls, and edema. The 9/6/23 Quarterly Minimum Data Set (MDS) assessment, indicated the resident was cognitively intact. The resident's vision was adequate with corrective lens. She had no oral	F 0685	**Munster Med INN** **Annual Survey: 11/20/2023** 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. **F685 Treatment /Devices to Maintain Hearing/Vision** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;** Orders were received from the physician for eye drops for resident 146. **How the facility will identify other residents having the potential to be affected by the**	12/04/2023

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	problems, weighed 122 pounds, and has had a significant weight loss. The resident received dialysis as a resident. An Optometry Progress Note, dated 4/13/23, indicated the resident had mild dry eyes for both eyes. Recommend a new medication order of Refresh Plus Ophthalmology Solution apply 1 drop into both eyes twice a day for indefinitely. The order was written and given to Social Service. At that time, new glasses were not recommended. An Optometry Progress Note, dated 5/24/23, indicated the resident now had moderate dry eyes for both eyes. "The patient states she never received eye drops from the last visit." A new medication order for Refresh Plus Ophthalmology Solution apply 1 drop into both eyes twice a day for indefinitely was written and given to and discussed with Social Service. Physician's Orders, dated 5/24/23, indicated Eye Drops Advanced Relief Ophthalmic Solution 0.05-0.1-1-1 %, instill 1 drop in both eyes two times a day for dry eyes. Interview with the Second Floor Unit Manager on 11/17/23 at 3:20 p.m., indicated the resident saw the eye doctor in 4/2023 and he did recommend Refresh eye drops for dry eyes. He wrote the script on a Physician's Order form, however, nursing never saw the order because it was given to Social Service. 3.1-39(a)(1)		**same deficient practice and what corrective action will be taken;** All facility residents requiring vision services 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 on ensuring optometry recommendations/follow up is completed timely. **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/designee will audit weekly to see if any residents were seen by optometry, if so the Unit Manager/designee will ensure recommendations are followed. Director of Nursing /designee will present a summary of the audits to the Quality Assurance committee monthly for 4 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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			12/4/2023	
F 0686 SS=D Bldg. 00	483.25(b)(1)(i)(ii) Treatment/Svcs to Prevent/Heal Pressure Ulcer §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. Based on observation, record review, and interview, the facility failed to ensure pressure ulcers were covered securely with a bandage as ordered by the Physician and treatment orders were obtained timely for new pressure sores for 2 of 4 residents reviewed for pressure ulcers. (Residents G and J) Findings include: 1. On 11/14/23 at 1:52 p.m., Resident G was observed in bed. At that time, their feet were observed laying directly on the mattress and not suspended or offloaded. The top right foot was observed with bloody scabs and the foot was bright red. There was no dressing observed. On 11/15/23 at 10:48 a.m., and 3:15 p.m., and	F 0686	**Munster Med-Inn** **Annual Survey: 11/20/2023** 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. **F686 Treatment/Svcs to Prevent/Heal Pressure Ulcers** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;**	12/04/2023

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11/16/23 at 9:15 a.m., 1:50 p.m., the resident was observed in bed. At those times, their feet were observed laying directly on the mattress and not suspended or offloaded. The top right foot was observed with bloody scabs and the foot was bright red.

On 11/17/23 at 8:04 a.m., the resident was observed in bed and their feet were laying directly on the mattress and not suspended or offloaded. There was a white bandage observed to the right foot dated 11/16/23.

During a wound treatment observation on 11/17/23 at 9:33 a.m., the wound care nurse was observed completing the treatment for the right foot. She removed the old bandage from the right foot. The area was bright red with multiple scabbed areas, and 2 dark purple sores were observed under the right foot. One area was hard with a black scab and the other area was open.

The record for Resident G was reviewed on 11/15/23 at 3:32 p.m. Diagnoses included, but were not limited to, multiple sclerosis, vascular dementia, major depressive disorder, mood disorder, paraplegia, hammer toes for left and right feet, right foot deformity, pain in the toes, fecal impaction, constipation, and anxiety.

The 9/14/23 Quarterly Minimum Data Set (MDS) assessment, indicated the resident was severely impaired for decision making and had short and long term memory problems. The resident needed extensive assist with 2 person physical assist for bed mobility and toileting, and an extensive assist with a 1 person physical assist for personal hygiene, dressing and eating. The resident was frequently incontinent of bowel and was not on a bowel toileting program.

Resident J's- treatment was immediately replaced.
Resident G's feet were immediately off-loaded. Resident G's MD was notified, and orders were obtained for newly identified pressure ulcer.

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 pressure ulcers 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 the following:
Ensuring ordered preventative measure are in place for at risk residents
Obtaining orders and implementing timely treatment for new skin conditions.
Notifying MD and resident responsible party of new skin conditions.
Replacing treatment dressings that are soiled or detached from wound timely.
Assistive staff were re-educated on:
Notifying the nurse immediately when a treatment has

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	A Care Plan, revised on 6/30/23, indicated the resident had impaired skin integrity to the right outer ankle. The approaches were to render treatment as per orders. A weekly skin observation, dated 11/14/23 at 12:12 a.m., indicated open lesions on the left and right feet that were not new. Wound care was being provided. A Wound Observation Assessment, dated 11/16/23, indicated the right lateral foot was observed with a deep tissue injury that measured 5 centimeters (cm) by 8 cm. There was 75% of epithelial (pale pink or red tissue. An old deep tissue injury to the right lateral foot was resolved on 8/3/23. Physician's Orders, dated 5/24/23, indicated to suspend or offload heels while in bed. Physician's Orders, dated 11/16/23, indicated cleanse right lateral foot with wound cleanser or normal saline, apply an Adaptic bandage, and cover with dry dressing every day shift on Monday, Wednesday, and Friday. May see the wound doctor. Interview with the Second Floor Unit Manager on 11/17/23 at 8:40 a.m., indicated the resident's heels should be offloaded while in bed. Interview with the Wound Nurse on 11/17/23 at 9:40 a.m., indicated while she was changing the resident's roommate's bandage yesterday and after the Wound Doctor had left, the CNA approached her and indicated she needed to look at Resident G's right foot. The Wound Nurse		become soiled or detached from wound. **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;** Wound nurse/designee will randomly audit 10 residents identified to be at risk for skin breakdown or with existing skin breakdown to ensure skin conditions are documented and orders obtained, and treatments are in place per orders. Director of Nursing/designee will present a summary of the audits to the Quality Assurance committee monthly for 4 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: 12/4/2023**	

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indicated this was the first time she was made aware the resident's right foot had open areas. The Wound Doctor had just left and did not assess the wound, however, he had treated this foot before. The Wound Doctor will assess the wound and treat next week during his rounds. The resident's heels should be suspended or offloaded while in bed. There were no further orders.

2. On 11/17/23 at 9:11 a.m., Resident J was observed in bed. The resident was just put back to bed at 8:30 a.m. At that time, the Wound Nurse was going to change the resident's bandage to the pressure ulcer on her coccyx. The Wound Nurse removed the resident's incontinent brief which was soaked with urine and there was no bandage covering the pressure ulcer. The pressure ulcer was red in color with white edges.

The record for Resident J was reviewed on 11/16/23 at 3:03 p.m.. Diagnoses included, but were not limited to, stroke, Alzheimer's disease, pressure ulcer of the sacral region, psychotic disorder, major depressive disorder, and osteoarthritis.

The 10/22/23 Modification of the Quarterly Minimum Data Set (MDS) assessment, indicated the resident was rarely understood/understands and was severely impaired for decision making. The resident had 1 stage 3 pressure ulcer.

The Care Plan, revised on 6/20/23, indicated the resident had a pressure ulcer to the sacral area. The approaches were to administer treatments as ordered and monitor for effectiveness, and monitor dressing to ensure it was intact and adhering. Report loose dressings to the treatment nurse.

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Physician's Orders, dated 11/16/23, indicated cleanse sacrum with normal saline, apply collagen, and cover with foam dressing every day shift on Monday, Wednesday, and Friday and as needed.

The last documented Wound Measurement was on 11/16/23 and the Stage 3 pressure ulcer measured 2.5 centimeters (cm) by 1.4 cm by 1.0 cm. The tissue had 30% slough (necrotic tissue) 40% granulation tissue and 30% other viable tissues) The wound progress was exacerbated due to the patient being non-compliant with wound care and resisting offloading efforts.

A Nurses' Note, dated 11/17/23 at 6:54 a.m., indicated the resident was gotten up out of bed per the CNA and their request. The resident was sitting up in the wheelchair by nurses station.

Interview with the Wound Nurse on 11/17/23 at 9:20 a.m., indicated she was unaware the pressure ulcer had no bandage over it.

The current and 9/1/20 "Skin Condition Assessment and Monitoring Pressure and Non Pressure" policy, provided by the Assistant Director of Nursing on 11/17/23 at 3:23 p.m., indicated pressure ulcers will be assessed and measured at least weekly by the licensed nurse and documented in the resident's clinical record. Dressings which were applied to pressure ulcers, skin tears, and wounds shall include the date of the licensed nurse who performed the procedure.

This citation relates to Complaint IN00420643.

3.1-40(a)(2)

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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 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 11 residents reviewed for ADL's. (Resident G) Finding includes: On 11/14/23 1:52 p.m., on 11/15/23 at 10:48 a.m. and 3:15 p.m., on 11/16/23 at 9:15 a.m. and 1:50 p.m., and on 11/17/23 at 8:04 a.m. and 9:33 a.m., Resident G was observed in bed. At those times the resident had long thick toenails with dry scaly skin on both feet. The record for Resident G was reviewed on 11/15/23 at 3:32 p.m. Diagnoses included, but were not limited to, multiple sclerosis, vascular dementia, major depressive disorder, mood disorder, paraplegia, hammer toes for left and right feet, right foot deformity, pain in the toes, fecal impaction, constipation, and anxiety. The 9/14/23 Quarterly Minimum Data Set (MDS)	F 0687	**Munster Med INN** **Annual Survey: 11/20/2023** 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 G was added to the facilities next podiatry visit list. **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;**	12/04/2023

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	assessment, indicated the resident was severely impaired for decision making and had short and long term memory problems. The resident needed extensive assist with 2 person physical assist for bed mobility and toileting, and an extensive assist with a 1 person physical assist for personal hygiene, dressing and eating. The resident was frequently incontinent of bowel and was not on a bowel toileting program. A Podiatry Exam note, dated 6/21/23, indicated the resident's toenails were reduced in length and thickness to 3 mm (millimeters). The next exam was to be as medically necessary but no sooner than 60 days. Interview with the Assistant Director of Nursing on 11/17/23 at 3:20 p.m., indicated the resident must have been in the hospital when the podiatrist was here last, as she was on the 60 day recall list to be seen on 11/21/23. Interview with the Second Floor Unit Manager on 11/20/23 at 9:00 a.m., indicated they trimmed the resident's toenails with a pair of large clippers. This citation relates to Complaint IN00418486. 3.1-47(a)(7)		All facility residents requiring podiatry services 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 service of any resident in need of foot care so that they may be added to the podiatry list. **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/designee will audit weekly to ensure new admissions are offered podiatry services and any resident with need for foot care is added to the podiatry visit list. Administrator /designee will present a summary of the audits to the Quality Assurance committee monthly for 4 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: 12/4/2023**	

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F 0690 SS=D Bldg. 00	483.25(e)(1)-(3) Bowel/Bladder Incontinence, Catheter, UTI §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. §483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. §483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel			

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	function as possible. Based on observation, record review, and interview, the facility failed to ensure a suprapubic foley (urinary) catheter bag not on the floor and catheter care was completed as ordered by the Physician for 1 of 1 residents reviewed for catheters. (Resident 12) Finding includes: On 11/14/23 at 11:09 a.m. and 2:47 p.m., and on 11/16/23 at 9:25 a.m. and 10:15 a.m., Resident 12 was observed in bed. At those times, the foley catheter was hanging on the side of the bed, however, the bag was touching the floor. On 11/16/23 at 11:30 a.m., the resident was observed in bed. CNA 1 was asked to remove his brief to observe the stoma site of the supra pubic catheter. The area around the catheter was dark brown and crusted over. The catheter bag was observed resting on the floor. On 11/17/23 at 7:45 a.m. and 8:26 a.m., the resident was observed in bed. At that time, the foley catheter bag was observed on floor. On 11/17/23 at 8:43 a.m., RN was asked to observe the resident's supra pubic ostomy site. The RN removed the brief and the same brown crusty tissue was observed around the stoma. Interview with RN 1 at that time, indicated it was the nurses' responsibility to provide catheter care for his suprapubic catheter. The record for Resident 12 was reviewed on 11/16/23 at 9:37 a.m. The resident was admitted to the facility on 7/26/23 from the hospital. Diagnoses included, but were not limited to, type	F 0690	**Munster Med-Inn** **Annual Survey: 11/20/2023** 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. **F690 Bowel/Bladder Incontinence, Catheter, UTI** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;** Resident 12's catheter was positioned off the floor and catheter care was rendered immediately. **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 indwelling catheters 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 catheter care	12/04/2023

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	2 diabetes, Parkinson's disease, stroke, dementia with other behavioral disturbance, urinary tract infections, obstructive uropathy, chronic kidney disease, and major depressive disorder. The Quarterly Minimum Data Set (MDS) assessment, dated 10/9/23, indicated the resident was moderately impaired for decision making and had no behaviors. The resident had an indwelling foley catheter and received an antipsychotic, antidepressant, and antiplatelet medications. A Care Plan, revised on 11/9/23, indicated the resident had a urinary catheter for neurogenic bladder. Physician's Orders, dated 10/2/23, indicated catheter care every shift. Physician's Orders, dated 11/13/23, indicated Foley catheter, size 16 French, balloon size 10 milliliters (ml). The Treatment Administration Record (TAR) indicated foley cath care was signed out as being completed 11/1-11/16/23. Interview with the Second Floor Unit Manager on 11/17/23 at 8:45 a.m., indicated the foley catheter bag should not be on the floor and the nurses were responsible to provide catheter care. 3.1-41(a)(2)		orders are in place and catheter care is rendered as per orders. Ensuring catheter drainage bag/tubing are positioned off 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;** Nurse managers will audit 2 residents with catheters 2 times per week to ensure catheter care is rendered per orders and catheter is positioned off the floor. The Director of Nursing/designee will present a summary of the audits to the Quality Assurance committee monthly for 4 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: 12/4/2023**	
F 0695 SS=D 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			

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	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 at the correct flow rate for 1 of 2 residents reviewed for oxygen. (Resident M) Finding includes: During an interview with Resident M on 11/14/23 at 11:48 a.m., the resident indicated they wore oxygen all the time. The oxygen flow rate was set at 2.5 liters per minute. On 11/15/23 at 10:09 a.m., and 2:30 p.m., the resident was observed wearing oxygen via nasal cannula. The oxygen flow rate was set at 3 liters per minute. The record for Resident M was reviewed on 11/16/23 at 11:03 a.m. Diagnoses included, but were not limited to, COPD (chronic obstructive pulmonary disease), anemia, chronic respiratory failure, major depressive disorder, high blood pressure, anxiety, and dependence on supplemental oxygen. The 9/29/23 Quarterly Minimum Data Set (MDS) assessment, indicated the resident was cognitively intact. The resident received oxygen as a resident and in the last 7 days she received an anticoagulant medication 7 times. A Care Plan, revised on 10/23/23, indicated the resident had oxygen therapy due to the diagnosis	F 0695	**Munster Med INN** **Annual Survey: 11/20/2023** 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/Tracheostomy Care and Suctioning** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;** Resident M- Oxygen flow rate was immediately corrected. **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**	12/04/2023

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	of COPD. Physician's Orders, dated 4/6/23, indicated oxygen via nasal cannula, administer at 2 liters per minute continuously. Interview with the Second Floor Unit Manager on 11/17/23 at 8:40 a.m., indicated the resident's oxygen should have been set at 2 liters per minute. 3.1-47(a)(6)		**ensure that the deficient practice does not recur;** Staff were re-educated on: Ensuring a physician order is obtained/in-place for oxygen. Oxygen is administered at the correct liter flow rate. Oxygen tubing is changed and labeled appropriately. **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 5 residents with oxygen 2 times per week to ensure oxygen is in place and set at the appropriate flow rate. Director of Nursing/designee will present a summary of the audits to the Quality Assurance committee monthly for 4 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: 12/4/2023**	

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F 0698 SS=D Bldg. 00	483.25(l) Dialysis §483.25(l) Dialysis. The facility must ensure that residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences.			
	Based on observation, record review, and interview, the facility failed to ensure a dialysis resident received the correct nutritional supplement for 1 of 1 residents reviewed for dialysis. (Resident 146) Finding includes: During random observations on 11/14/23 at 2:50 p.m., 11/15/23 at 2:30 p.m., and 11/16/23 at 3:10 p.m., there was a container of Boost nutritional supplement on Resident 146's over bed table. Interview with the resident on 11/14/23 at 2:50 p.m., indicated she goes to dialysis on Tuesdays, Thursdays, and Saturdays. The Boost supplement was given to her from the nursing staff at the facility. She indicated she gets them two times a day. On 11/17/23 at 7:46 a.m., the resident was observed eating breakfast. At that time, there were 2 containers of the Boost nutritional supplement on her over bed table. The record for Resident 146 was reviewed on 11/16/23 at 1:25 p.m. Diagnoses included, but were not limited to, hypertensive chronic kidney disease, type 2 diabetes, end stage renal disease, dependence on renal dialysis, acute kidney failure, repeated falls, and edema.	F 0698	**Munster Med-Inn** **Annual Survey: 11/20/2023** 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. **F698 Dialysis** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;** Resident 146- Ensure supplement was immediately removed from resident's bedside. The dialysis dietician was contacted, and new orders were obtained for boost supplement per resident preference. **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 requiring dialysis services have the potential to be	12/04/2023

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	The 9/6/23 Quarterly Minimum Data Set (MDS) assessment, indicated the resident was cognitively intact. The resident's vision was adequate with corrective lens. She had no oral problems, weighed 122 pounds, and has had a significant weight loss. The resident received dialysis as a resident The Care Plan, revised on 10/27/23, indicated the resident required dialysis related to renal failure. The approaches were to provide a house supplement of Nepro 237 milliliters (ml) two times a day. Physician's Orders, dated 10/10/23, indicated house supplement of Nepro 237 ml two times a day. Physician's Orders, dated 8/29/23, indicated dialysis every Tuesday, Thursday, and Saturday. Interview with the Second Floor Unit Manager on 11/17/23 at 8:45 a.m., indicated the resident was to receive the Nepro supplement due to being a dialysis patient. 3.1-37(a)		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 were re-educated on providing supplements as per physician 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 audit 2 dialysis residents being administration supplements 2 times per week to ensure appropriate supplement is provided. The Director of Nursing/designee will present a summary of the audits to the Quality Assurance committee monthly for 4 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: 12/4/2023**	
F 0757 SS=D Bldg. 00	483.45(d)(1)-(6) Drug Regimen is Free from Unnecessary Drugs			

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	§483.45(d) Unnecessary Drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used- §483.45(d)(1) In excessive dose (including duplicate drug therapy); or §483.45(d)(2) For excessive duration; or §483.45(d)(3) Without adequate monitoring; or §483.45(d)(4) Without adequate indications for its use; or §483.45(d)(5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or §483.45(d)(6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section.			
	Based on record review and interview, the facility failed to manage medications appropriately related holding blood pressure medications on dialysis days and checking blood pressure and pulse prior to the administration of blood pressure medications with Physician ordered parameters for 1 of 5 residents reviewed for unnecessary medications. (Resident 146) Finding includes: The record for Resident 146 was reviewed on 11/16/23 at 1:25 p.m. Diagnoses included, but were not limited to, hypertensive chronic kidney disease, type 2 diabetes, end stage renal disease, dependence on renal dialysis, acute kidney failure, repeated falls, and edema.	F 0757	**Munster Med-Inn** **Annual Survey: 11/20/23** 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. **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;** Resident 146's- physician was	12/04/2023

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	The 9/6/23 Quarterly Minimum Data Set (MDS) assessment, indicated the resident was cognitively intact. The resident's vision was adequate with corrective lens. She had no oral problems, weighed 122 pounds, and has had a significant weight loss. The resident received dialysis as a resident. The Care Plan, revised on 10/27/23, indicated the resident required dialysis related to renal failure. Physician's Orders, dated 8/29/23, indicated dialysis every Tuesday, Thursday, and Saturday. Physician's Orders, dated 5/23/23, indicated Hydralazine (a medication used to lower the blood pressure) 100 milligrams (mg), give 1 tablet three times a day. Physician's Orders, dated 7/6/23, indicated Carvedilol (a medication used to lower the blood pressure and decrease the heart rate) 3.125 mg, give 1 tablet every morning at bedtime for high blood pressure. May hold the morning dose on Tuesdays, Thursdays, and Saturdays for dialysis. Physician's Orders, dated 9/16/23, indicated hold blood pressure medications on Dialysis days in the morning every Tuesday, Thursday, and Saturday. The Medication Administration Record (MAR) for the months of 9/2023, 10/2023 and 11/2023 indicated the Carvedilol was administered on 9/16, 9/19, 9/21, 9/23, 9/26, 9/28, 10/3, 10/5, 10/10, 10/12, 10/17, 10/19, 10/21, 10/26, 10/28, 10/31, 11/2 and 11/4/23, all of which were dialysis days. The Physician's Order for the Carvedilol was		notified and clarification was received for blood pressure parameters and medications to be held on dialysis days. Orders were updated. **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 with medication parameters 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 in-serviced on following blood pressure parameters as ordered before administering medication. Nurses were in-serviced on holding mediations as per orders/administering medications per parameters. **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 Medication Administration Record (MAR) weekly to ensure medications are being administered/held per physician parameters.	

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	changed on 11/7/23. The new order was Carvedilol 6.25 mg one time a day. Hold for heart rate less than 60 and/or systolic blood pressure less than 100. The 11/2023 MAR indicated the Carvedilol was to be administered at 9:00 a.m. There was no heart rate or blood pressure documented before the administration of the medication. Interview with the Second Floor Unit Manager on 11/20/23 at 9:00 a.m., indicated the blood pressure medications should have been held on dialysis days as ordered and the resident's blood pressure and pulse should be checked prior to the administration of the medication. 3.1-48(a)(3)		The Director of Nursing/designee will present a summary of the audits to the Quality Assurance committee monthly for 4 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: 12/4/2023**	
F 0758 SS=D Bldg. 00	483.45(c)(3)(e)(1)-(5) Free from Unnec Psychotropic Meds/PRN Use §483.45(e) Psychotropic Drugs. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic Based on a comprehensive assessment of a resident, the facility must ensure that--- §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and			

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	documented in the clinical record; §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and §483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order. §483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication.			
	Based on record review and interview, the facility failed to ensure there was an indication for the use of a psychotropic medication for 1 of 5 residents reviewed for unnecessary medications. (Resident 23) Finding includes: The record for Resident 23 was reviewed on 11/16/23 at 11:00 a.m. Diagnoses included, but were not limited to, high blood pressure, anemia,	F 0758	Munster Med-Inn Annual Survey: 11/20/2023 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.	12/04/2023

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	dementia, anxiety, behavior disturbance, insomnia and depression. The Quarterly Minimum Data Set (MDS) assessment, dated 9/28/23, indicated the resident was severely impaired for decision making. In the last 7 days the resident had received an antidepressant and an antipsychotic medication. A Care Plan, dated 9/28/23, indicated the resident displayed physical behavioral symptoms related to hitting a peer. Interventions included, but were not limited to, refer to psychologist/psychiatrist for behavior management as needed. A Physician's Order, dated 5/15/23, indicated for Olanzapine (antipsychotic medication) 5 milligrams(mg) be administered at bedtime related to dementia. A Nurse's Note, dated 11/3/23 at 8:18 a.m., indicated the resident's gradual dose reduction (GDR) was contraindicated due to the resident's stable condition on current medication regimen. The resident was not seen by the outside behavioral contracted services. There were no psychologist/psychiatrist progress notes to be reviewed. Interview with the Director of Nursing on 11/16/23 at 12:40 p.m., indicated the resident was on an antipsychotic medication related to a behavior disturbance diagnosis and the resident had not been seen by any other behavioral services. 3.1-48(a)(4)		**F758 Free from unnecessary psychotropic meds/PRN use** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;** Resident 25's- physician was notified and a diagnosis/indication for use was obtained for olanzapine. **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 psychotropic medications 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 on ensuring there is an appropriate diagnosis/indication for use for psychotropic medications. **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 Services Director/Designee will randomly audit 5 residents receiving psychotropic medications weekly to ensure	

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			there is an appropriate diagnosis/indication for use. The Director of Nursing/designee will present a summary of the audits to the Quality Assurance committee monthly for 4 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: 12/4/2023**	
F 0812 SS=F Bldg. 00	483.60(i)(1)(2) Food Procurement,Store/Prepare/Serve-Sanitary §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility.			

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	§483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. Based on observation, record review, and interview, the facility failed to serve food under sanitary conditions related to beverages being uncovered while being transported down the hallway for 1 of 1 meal observations. The facility also failed to store and prepare food under sanitary conditions related to dried spillage on the floor, walls, and door, and a build up of grease and grime on the food preparation equipment for 1 of 1 kitchens. (The Fourth Floor and the Main Kitchen) Findings include: 1. On 11/17/23 at 11:32 a.m., the beverage cart was delivered to the Fourth floor. At 11:50 a.m., a staff member was observed placing 10 styrofoam cups on the ledge of the nurses' station and filling them with juice. At 11:52 a.m., staff members were observed placing the uncovered cups on residents' lunch trays and walking down the hall. Interview with the Assistant Director of Nursing (ADON) on 11/20/23 at 3:18 p.m., indicated the cups should have been covered. The facility policy titled "In-Room Dining" was provided by the ADON on 11/20/23 at 3:18 p.m. and identified as current. The policy indicated all foods should be covered during transport. 2. During the initial kitchen tour on 11/14/23 at 8:47 a.m. with the Food Service Director, the following was observed: a. The stove top and fire irons had a build up of	F 0812	**Munster Med INN** **Annual Survey: 11/20/2023** 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. **F812 Food Procurement, Store/Prepare/Serve/Sanitary** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;** Beverages being transported down the hall were immediately covered appropriately. Liquid spills were cleaned from floors, doors, and walls. Grease and grim was cleaned from the food preparation equipment including the stove top and fire irons. The cup of undated food in the cooler was immediately discarded. The convection oven was cleaned of dried food and grease built up on top and inside. **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;**	12/04/2023

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	grease and debris. b. There were cups of food in the cooler without dates. c. There was brown liquid spillage on the walls by the entry door, on the floor, and behind the appliances. d. The convection oven had dried food and a build up of grease on the top and dried food and grease build up on the inside. Interview with the Food Service Director on 11/14/23 at 9:00 a.m., indicated she was working on a cleaning schedule, job assignments and setting up inservices for the staff. 3.1-21(i)(3)		All residents have the potential to be 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;** Dietary managers/dietary staff were re-educated on: Keeping clean of debris such as liquid spills, splashes, grease and grim build up. Keeping convection oven/oven clean Properly labeling/dating food in cooler Staff were educated on: Covering food and beverages before transporting **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 kitchen 2 times per week to ensure cleanliness/sanitation of the kitchen areas is maintained. Facility Angel's will audit meal tray pass 3 times per week to ensure food/beverages are covered prior to transferring to resident rooms. Administrator/designee will present a summary of the audits to the Quality Assurance committee monthly for 4 months. Thereafter, if determined by the	

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			Quality Assurance committee, auditing and monitoring will be done quarterly and present quarterly at the QA meeting. **Date by which systemic corrections will be completed: 12/4/2023**	
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 dirty floors, marred walls, loose baseboards, lime build up, missing tiles, and personal care items not contained for 4 of 5 floors throughout the facility. (The Second, Third, and Fourth floors) Findings include: During the Environmental tour with the Maintenance and Housekeeping Supervisors on 11/20/23 at 9:38 a.m., the following was observed: 1. Second Floor a. On 11/14/23 at 10:52 a.m., Room 205 was observed. The floor mats were dirty, there was an accumulation of food debris on the floor in between the beds, the raised toilet seat was cracked, and the corners of the bathroom floor were dirty. The resident was currently out on hospital leave. b. The bathroom faucet in Room 213 had a heavy accumulation of lime build up. There was a	F 0921	**Munster Med INN** **Annual Survey: 11/20/2023** 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;** Housekeeping was notified of cleaning needs for rooms: 205, 213, 215, 220, 223, 325, and 329 including dirty floors, faucet build up, dirty floor mats, soiled nightstand, and soiled bedside commode. Maintenance was notified of need	12/04/2023

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	11/20/2023

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	missing ceramic wall tile next to the toilet, and the walls were marred in the room. One resident resided in the room and 3 residents shared the bathroom. c. In the bathroom of Room 215, there was a toothbrush face down on the ledge below the mirror and there was a urinal on the top ledge below the mirror. There was also a pool of water underneath the toilet. Two residents shared the bathroom. d. The tile floor in Room 220 had an accumulation of dust and dirt and was in need of cleaning. Two residents resided in this room. e. There was dirt and debris on the floor of Room 223. The corner night stand also had an accumulation of dried spillage. One resident resided in this room. 2. Third Floor a. The floor tile in Room 325 was dusty and dirty. The wall by bed 1 was scratched and marred. b. The bedside commode in Room 329 for bed 2 had bowel movement in the container. 3. Fourth Floor a. The wall behind bed 2 in Room 407 was scratched and marred. Two residents resided in the room. b. The wall behind bed 1 in Room 408 was scratched and marred and the baseboard was peeling away from the wall. One resident resided in this room.		for repairs needed in rooms: 205, 213, 325, 407, and 408 including cracked toilet seat, scratched walls, marred walls, and peeling baseboards. Resident personal items were stored/appropriately contained. **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 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 on: Notifying maintenance/environmental services of any necessary repairs or cleaning needed. Keeping residents' personal items contained/stored properly. **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;** The Maintenance Director will audit 5 rooms per week on alternating units for maintenance issues. Any issues will be corrected. Facility Angel’s will audit 10	

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	Interview with the Maintenance and Housekeeping Staff at that time, indicated all of the above were in need of cleaning and/or repair. This citation relates to Complaint IN00420643. 3.1-19(f)		resident rooms 3 times per week to ensure personal items are contained/stored properly. The Administrator/designee will present a summary of the audits to the Quality Assurance committee monthly for 4 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: 12/4/2023**	