STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE C	ONSTRUCTION	OMB NO. 0938-039 (X3) DATE SURVEY COMPLETED 11/20/2023	
	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING B. WING	<u>00</u>		
	PROVIDER OR SUPPLIEF	• 1	STREET 7935 (•		
MUNSTE	ER MED-INN		MUNS	TER, IN 46321		
(X4) ID		STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRECT	ION	(X5)
PREFIX		CY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPR DEFICIENCY)	OPRIATE	COMPLETION
TAG 0000	REGULATORY OF	R LSC IDENTIFYING INFORMATION	TAG			DATE
0000						
3ldg. 00	Licensure Survey. 7 Investigation of Co IN00419836, IN004 Complaint IN00418 related to the allega F687. Complaint IN00419 related to the allega Complaint IN00420 the allegations are of Complaint IN00420 related to the allega and F921. Survey dates: Nove 2023. Facility number: 00 Provider number: 11 AIM number: 1002 Census Bed Type: SNF/NF: 157 Total: 157 Census Payor Type Medicare: 14 Medicaid: 126 Other: 17	0643 - Federal/state deficiencies tions are cited at F684, F686, ember 14, 15, 16, 17, and 20, 00056 155131 289450	F 0000	The Facility respectfully as desk review.	sks for a	
	Total: 157					
	These deficiencies	reflect State Findings cited in				
ABORATO	RY DIRECTOR'S OR PRO	VIDER/SUPPLIER REPRESENTATIVE'S S	IGNATURE	TITLE		(X6) DATE
hanika wi	:III-:+-		Adminis	4		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.

000056

PRINTED: 12/20/2023 FORM APPROVED

	NT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155131	(X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING		(X3) DATE SURVEY COMPLETED 11/20/2023	
	NAME OF PROVIDER OR SUPPLIER MUNSTER MED-INN			ADDRESS, CITY, STATE, ZIP COD CALUMET AVE TER, IN 46321		
(X4) ID PREFIX TAG	(EACH DEFICIE	/ STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL IR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	(X5) COMPLETION DATE	
F 0554 SS=D Bldg. 00	 483.10(c)(7) Resident Self-Ad §483.10(c)(7) Th medications if the defined by §483. that this practice Based on observati interview, the faci had Physician's Or assessment to self- medications for 1 self-administration Finding includes: On 11/16/23 at 3:1 observed. At that the eye drops on the or not in her room. On 11/17/23 at 7:4 observed in bed eat there was a box of bed table. The resider of the	 mpleted on 11/27/23. Imin Meds-Clinically Approp e right to self-administer e interdisciplinary team, as 21(b)(2)(ii), has determined is clinically appropriate. ion, record review, and lity failed to ensure residents rders for medications and an administer their own of 1 residents reviewed for n of medication. (Resident 146) 0 p.m., Resident 146's room was ime, there was a box of Ivizia ver bed table. The resident was ting breakfast. At that time, Tvizia eye drops on the over dent indicated she put the eye when she needed them. sident 146 was reviewed on m. Diagnoses included, but were vertensive chronic kidney betes, end stage renal disease, al dialysis, acute kidney failure, 	F 0554	Munster Med INN Annual Survey: 11/20/2023 Please accept the following as facility's credible allegation of compliance. This plan of correction does not constitute a admission of guilt or liability by 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 medica assessment was completed for resident 146. The physician wa notified, and orders were obtai for lvizia eye drops and for res 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;	an the ation r as ned ident	

STATEME	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE C	ONSTRUCTION	(X3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING	00	COMPLETED
		155131	B. WING		11/20/2023
NAME OF	PROVIDER OR SUPPLIE	R		ADDRESS, CITY, STATE, ZIP COD	•
MUNST	ER MED-INN		MUNS	TER, IN 46321	
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	(EACH DEFICIE	NCY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	COMPLETIC
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)	DATE
	corrective lens. Sh	e had no oral problems,		All facility residents with	
	weighed 122 poun	ds, and has had a significant		medication orders have the	
	weight loss. The re	esident received dialysis as a		potential to be affected by the	
	resident.			same alleged deficient practic	e.
				What measures will be put in	nto
	There was no Phys	sician's Order for the Ivizia eye		place or what systemic	
	drops, nor was the	re a self-administration		changes will be made to	
	assessment for the	resident to administer her own		ensure that the deficient	
	eye drops.			practice does not recur;	
				Staff were educated on not lea	aving
	Interview with the	Second Floor Unit Manager		medications at resident bedsid	•
		at 8:45 a.m., indicated she was		unless there is an order for	
		ent had eye drops in her room.		self-administration and a	
		5 1		self-administration assessmer	nt
	Interview with the	Second Floor UM on 11/17/23		completed.	
		ated she asked the resident		How the corrective action(s)	
	-	eye drops from and she told her		will be monitored to ensure	
		She used the eye drops when		deficient practice will not	,ne
	-	or her dry eyes. The UM called		recur, i.e., what quality	
		asked about the eye drops and		assurance programs will be	nut
	-	/ did give them to her and they		into place;	put
		needed for dry eyes.		Facility Angel's will audit 10	
	were to be used as	ficeded for dry cycs.		residents 3 days per week to	
	The current $0/1/20$	20 "Medication Storage" policy,		ensure no medication is	
		ssistant Director of Nursing on			do
		.m., indicated the facility should		improperly stored at the bedsi	ue
	-	side medications without a		and any medication noted at bedside has orders for	
		The medications should be		self-administration.	
		compartment within the		The Director of Nursing/design	nee
	resident's room.			will present a summary of the	
	2.1.11()			audits to the Quality Assurance	
	3.1-11(a)			committee monthly for 4 mont	
				Thereafter, if determined by th	
				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	

STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE (CONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER 155131	A. BUILDING <u>00</u> B. WING		COMPLETED 11/20/2023	
NAME OF I	PROVIDER OR SUPPLIE	ER		TADDRESS, CITY, STATE, ZIP CALUMET AVE	COD	
MUNSTE	ER MED-INN			STER, IN 46321		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CO		(X5)
PREFIX	,	NCY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE		COMPLETION
TAG	REGULATORY C	R LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)		DATE
				corrections will be co 12/4/2023	ompleted:	
- 0656 SS=D	483.21(b)(1)(3)					
Bldg. 00		ent Comprehensive Care Plan prehensive Care Plans				
5lug. 00		e facility must develop and				
		prehensive person-centered				
		h resident, consistent with				
	•	s set forth at §483.10(c)(2)				
		B), that includes measurable				
		meframes to meet a				
		al, nursing, and mental and eds that are identified in the				
	comprehensive a					
		are plan must describe the				
	following -	•				
	-	hat are to be furnished to				
		n the resident's highest				
	practicable physi					
		I-being as required under				
		5 or §483.40; and that would otherwise be				
		483.24, §483.25 or §483.40				
	-	ded due to the resident's				
		under §483.10, including				
	•	e treatment under §483.10(c)				
	(6).					
		ed services or specialized				
		vices the nursing facility will				
	provide as a resu					
		s. If a facility disagrees with				
	-	e PASARR, it must indicate e resident's medical record.				
		n with the resident and the				
	resident's repres					
		s goals for admission and				
	desired outcome	-				
		s preference and potential for	1	1		1

STATEME	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE C	ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER 155131	A. BUILDING <u>00</u> B. WING		00	COMPLETED 11/20/2023	
NAME OF		D		STREET	ADDRESS, CITY, STATE, ZIP COD		
	PROVIDER OR SUPPLIE	ĸ					
MUNST	ER MED-INN			MUNS	TER, IN 46321		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	,	NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPR	IATE	COMPLETIO
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	-	Facilities must document lent's desire to return to the					
		assessed and any referrals					
	-	gencies and/or other					
		es, for this purpose.					
		ans in the comprehensive					
		propriate, in accordance with					
		set forth in paragraph (c) of					
	this section.						
		e services provided or					
		acility, as outlined by the					
	comprehensive c	-					
	(iii) Be culturally-	-					
	trauma-informed						10/04/000
		eview and interview, the facility	F 0	656	Munster Med-Inn		12/04/202
		are Plans related to pressure tion use for 2 of 33 residents			Annual Survey: 11/20/2023		
		were reviewed. (Residents N			Please accept the following a	ac the	
	and 12)	were reviewed. (Residents iv			facility's credible allegation of		
					compliance. This plan of	1	
	Findings include:				correction does not constitute	e an	
					admission of guilt or liability	by the	
	1. The record for	Resident N was reviewed on			facility and is submitted only	-	
	11/16/23 at 2:23 p	.m. Diagnoses included, but			response to the regulatory		
		o, palliative care, dementia with			requirement.		
		ce, and peripheral vascular			F656 Develop/Implement		
	disease (PVD).				Comprehensive Care Plan		
					What corrective action(s) w	vill	
		nimum Data Set (MDS)			be accomplished for those		
		8/15/23, indicated the resident			residents found to have be	en	
		npaired for daily decision ent required extensive			affected by the deficient		
	assistance for bed	-			practice; Resident 12's – care plan wa	ae an	
		moonity.			implemented related to	10	
	The "Wound Rour	nds" Progress Notes indicated			antidepressant, antipsychotic	and	
		e following wounds present:			anticoagulant medications.	., and	
		eable (full-thickness pressure			Resident N's – Care plan wa	S	
	-	he base was obscured by			implemented related to press		
	-	ar) pressure ulcer to the right			ulcers.		
	posterior upper thi				How the facility will identify	,	

	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155131	(X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING		(X3) DATE SURVEY COMPLETED 11/20/2023	
NAME OF	PROVIDER OR SUPPLIE	ĒR		TADDRESS, CITY, STATE, ZIP COD		
MUNST	ER MED-INN			STER, IN 46321		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX	(EACH DEFICIE	NCY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPR	IATE COMPLETIC	
TAG	REGULATORY C	OR LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)	DATE	
	10/21/22 5+ 2	(other residents having the	h	
	the left posterior u	(open wound) pressure ulcer to		potential to be affected by t		
	the feft posterior u	pper ungn.		same deficient practice and what corrective action will I		
	11/10/23 Deep T	issue Injury (purple or maroon		taken:	be	
	-	iscolored intact skin or blood		All residents have the potent	ial to	
	filled blister) to th			be affected by the same alleg		
				deficient practice.	y~~	
	- 11/10/23 Deep T	issue Injury to the left upper		What measures will be put i	into	
	buttock.			place or what systemic		
				changes will be made to		
	The current Care I	Plan did not address the		ensure that the deficient		
	resident's pressure ulcers.			practice does not recur;		
				Clinical staff were re-educate	ed on	
	Interview with the	Assistant Director of Nursing		completing care plans for		
		/23 at 3:00 p.m., indicated the		residents related to medication	ons	
	-	ulcers should have been		and skin conditions timely.		
		urrent Care Plan. 2. The record		How the corrective action(s		
		as reviewed on 11/16/23 at 9:37		will be monitored to ensure	the	
		was admitted to the facility on		deficient practice will not		
		ospital. Diagnoses included,		recur, i.e., what quality		
		ed to, type 2 diabetes,		assurance programs will be	e put	
		e, stroke, dementia with other ance, urinary tract infections,		into place; MDS/designee will randomly	a	
		hy, chronic kidney disease, and				
	major depressive of	3		10 residents weekly to ensur care plans are in place. With		
	major aepressive e			special focus on anticoagular		
	The Ouarterly Mir	nimum Data Set (MDS)		antipsychotics, antidepressa		
	· ·	10/9/23, indicated the resident		and pressure ulcer care plan		
		paired for decision making and		MDS/designee will present a		
		The resident had an indwelling		summary of the audits to the		
	foley catheter and	received antipsychotic,		Quality Assurance committee		
	antidepressant, and	d antiplatelet medications.		monthly for 4 months. There if determined by the Quality	after,	
	There were no Car	re Plans for the antipsychotic,		Assurance committee, auditi	ng	
		d antiplatelet medications.		and monitoring will be done	ř	
		-		quarterly and present quarter	rly at	
	Physician's Orders	s, dated 10/10/23, indicated		the QA meeting. Monitoring	-	
		idepressant medication) 150		be on going.		
	milligrams (mg) d	aily, aspirin (an antiplatelet				

	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155131	(X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING			(X3) DATE SURVEY COMPLETED 11/20/2023	
	PROVIDER OR SUPPLIE	R		7935 C	ADDRESS, CITY, STATE, ZIP COD ALUMET AVE TER, IN 46321		
(X4) ID PREFIX TAG	(EACH DEFICIE) REGULATORY O	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION one time a day, and Olanzapine		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPRO DEFICIENCY) Date by which systemic	ON D BE DPRIATE	(X5) COMPLETION DATE
⁻ 0677 SS=E Bldg. 00	(an antipsychotic r Interview with the 11/17/23 at 8:40 a. the resident's Care the MDS departmed Interview with the on 11/17/23 at 10:0 medications on the have had a Care Pl 3.1-35(a) 483.24(a)(2) ADL Care Provid §483.24(a)(2) A r carry out activitie necessary service nutrition, groomin hygiene;	hedication) 5 mg at bedtime. Second Floor Unit Manager on m., indicated she was unaware Plans were not completed as nt was responsible for those. Assistant Director of Nursing 00 a.m., indicated the MDS assessments should an.			corrections will be comp 12/4/2023	leted:	
	interview, the facil residents received daily living (ADL' shaving for 4 of 13 (Residents E, G, F, Findings include: 1. On 11/15/23 at observed in their re- substance was obse- fingernails on both resident was dresse in their room. The underneath their fin	10:15 a.m., Resident E was bom in bed. A brown erved underneath their hands. At 2:45 p.m., the d and seated in his wheelchair brown substance remained	F 06	577	Munster Med INN Annual Survey: 11/20/20 Please accept the followin facility's credible allegation compliance. This plan of correction does not constit admission of guilt or liabilit facility and is submitted on response to the regulatory requirement. F677 ADL Care Provided Dependent Residents What corrective action(s) be accomplished for thos residents found to have the affected by the deficient practice;	g as the n of ute an y by the ly in for will se	12/04/202

	NT OF DEFICIENCIES OF CORRECTION	x1) provider/supplier/clia identification number 155131	(X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING		(X3) DATE SURVEY COMPLETED 11/20/2023	
NAME OF	PROVIDER OR SUPPLIE	ER		ADDRESS, CITY, STATE, ZIP COD		
MUNST	ER MED-INN			CALUMET AVE TER, IN 46321		
	SUMMAD	Y STATEMENT OF DEFICIENCIE	ID	,	(V5)	
(X4) ID PREFIX		ENCY MUST BE PRECEDED BY FULL	PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	(X5)	
TAG		OR LSC IDENTIFYING INFORMATION	TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	DATE	
		ce remained underneath the		Assistance with grooming	Dille	
	resident's fingerna			including nail care and shavin	a	
	8			was provided to residents E, (•	
	The record for Re	sident E was reviewed on		and F.	-, _,	
	11/16/23 at 9:51 a	.m. Diagnoses included, but		How the facility will identify		
		o, stroke, dementia with other		other residents having the		
		nce, major depressive disorder,		potential to be affected by th	ne	
	and chronic kidne			same deficient practice and		
				what corrective action will b	e	
	The Quarterly Min	nimum Data Set (MDS)		taken;		
	assessment, dated	9/11/23, indicated the resident		All dependent residents have	the	
	was moderately in	npaired for daily decision		potential to be affected by the		
		moderate assistance with		same alleged deficient practic	e.	
	personal hygiene,	and was dependent on staff for		What measures will be put in	nto	
	bathing.			place or what systemic		
				changes will be made to		
		received a complete bed bath on		ensure that the deficient		
	11/4, 11/6, 11/7, 1	1/8, 11/12, 11/13, and 11/15/23.		practice does not recur;		
				Staff were re-educated on		
	-	was given on 11/10 and		providing dependent residents		
	11/14/23.			assistance with Activities of D		
	NT '1 1			Living (ADL's) including shavi	ng	
		umented as being completed on $1/0$, $11/12$, and $11/12/22$. Notificant		and nail care.		
		1/9, 11/12, and 11/13/23. Nail care		How the corrective action(s)		
	11/15/23 at 10:08	ated as being completed on		will be monitored to ensure t	the	
	11/13/25 at 10.08	a.m.		deficient practice will not		
	Interview with the	e Assistant Director of Nursing		recur, i.e., what quality assurance programs will be	nut	
		3 p.m., indicated the resident's		into place;	Pur	
		been cleaned during care.		Facility Angel's will Audit 10		
		52 p.m., on 11/15/23 at 10:48 a.m.		residents weekly, to ensure		
		11/16/23 at 9:15 a.m. and 1:50		assistance with ADL's is being	- I	
	-	7/23 at 8:04 a.m. and 9:33 a.m.,		provided with a special focus		
	-	bserved in bed. At those times		shaving and nail care.		
		ong gray facial hair under their		Director of Nursing/designee	will	
	chin.			present a summary of the aud		
				to the Quality Assurance		
	The record for Rea	sident G was reviewed on		committee monthly for 4 mont	hs.	
		.m. Diagnoses included, but were		Thereafter, if determined by the		
	-	ltiple sclerosis, vascular		Quality Assurance committee		

NTERS FOR MEDICARE & MEDICAID SERVICES							
STATEME	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2)	MULTIPLE CO	ONSTRUCTION	(X3) DAT	E SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	А.	BUILDING	00	COMPLETED	
		155131	В.	WING		11/2	0/2023
NAME OF	PROVIDER OR SUPPLIEF	3			ADDRESS, CITY, STATE, ZIP	COD	
	ER MED-INN						
NUNST				MUNS	TER, IN 46321		_
X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CO		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE		COMPLET
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
		pressive disorder, mood			auditing and monitori	ng will be	
		a, hammer toes for left and right			done quarterly and pr	resent	
	feet, right foot defo	rmity, pain in the toes, fecal			quarterly at the QA m	neeting.	
	impaction, constipation, and anxiety.				Monitoring will be on	going.	
	The 9/14/23 Quarte			Date by which syste	mic		
	assessment, indicate			corrections will be c			
		on making and had short and			12/4/2023		
	-	problems. The resident needed					
		h 2 person physical assist for					
		ileting, and an extensive assist					
		vsical assist for personal					
		nd eating. The resident was					
		ent of bowel and was not on a					
	bowel toileting prog						
	A Care Plan, revise	d on 9/1/23, indicated the					
		s in self care. The approaches					
	were						
	provide assistance t	to the extent needed for					
	-	eating, toileting, personal					
	hygiene, oral care a	e					
	There was no docur	mentation the resident rejected					
	or refused care for p	personal hygiene.					
		ation indicated the resident					
	-	ed bed bath on 11/9, 11/10,					
	11/11, 11/12, and 1	1/14/23.					
	Interview with the S	Second Floor Unit Manager on					
	11/17/23 at 8:40 a.r	n., indicated the resident does					
		their facial hair should have					
	been removed.3. On	n 11/15/23 at 10:36 a.m.,					
		erved with long dirty					
		ident indicated they had been					
	cut "once."						
	On 11/16/23 at 10:2	24 a.m., the resident's fingernails					
		and their shirt had food					

	NT OF DEFICIENCIES	CAID SERVICES X1) PROVIDER/SUPPLIER/CLIA		CONSTRUCTION	(V2) D + T	OMB NO. 0938-039 (X3) DATE SURVEY		
					. ,			
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING <u>00</u> B. WING			PLETED		
		155131	B. WING		11/20/2023			
NAME OF	PROVIDER OR SUPPLIE	R		T ADDRESS, CITY, STATE, ZIP	COD			
MUNST	ER MED-INN		MUNS	STER, IN 46321				
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CO	ORRECTION	(X5)		
PREFIX	(EACH DEFICIE	NCY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE	SHOULD BE	COMPLETIC		
TAG		OR LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)		DATE		
	crumbs and stains	on it.						
	Resident F's recor	d was reviewed on 11/15/23 at						
		bses included, but were not						
	-	ia, Parkinson's , anemia,						
		a blood pressure), seizure						
		tion, and insomnia (difficulty						
	sleeping).	, ()						
		nimum Data Set (MDS)						
		9/19/23, indicated the resident						
		npaired for daily decision						
	-	ent required partial/moderate						
		leting, upper and lower body ing. Oral hygiene required						
	-	ching and eating required set						
	up/clean up.	ening and eating required set						
	up/ crean up.							
	A Care Plan, dated	19/19/23, indicated the resident						
		icit with ADLs including bed						
		ansfers, and toileting.						
		ided, but were not limited to,						
		bility, eating, transfers, and						
	toileting as needed	1.						
	A Nurse's Note, da	ated 9/19/23 at 9:04 a.m.,						
		ent required assistance with						
	ADLs related to P							
	Nail care was last	provided on 10/20/23.						
		Assistant Director of Nursing						
	. ,	/23 at 1:44 p.m., indicated the						
	resident needed th	eir nails cut.						
	4 On $\frac{11}{15}/22$ of	2:38 p.m., Resident B was						
		eral light gray whiskers on their						
	chin.	erar nent gruy whiskers on their						
	On 11/16/23 at 10	:56 a.m., Resident B was						
	0111/10/23 at 10	u.m., resident D was				1		

	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155131	(X2) MULTIPLE CC A. BUILDING B. WING	DNSTRUCTION 00					
NAME OF	NAME OF PROVIDER OR SUPPLIER MUNSTER MED-INN			STREET ADDRESS, CITY, STATE, ZIP COD 7935 CALUMET AVE					
MUNSTI				MUNSTER, IN 46321					
(X4) ID PREFIX	(EACH DEFICIE	Y STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE /	HOULD BE	(X5) COMPLETION			
TAG	observed laying in	R LSC IDENTIFYING INFORMATION bed, and the whiskers were still n. The resident expressed they	TAG	DEFICIENCY)		DATE			
	3:39 p.m. Diagnos to, dementia, heart	d was reviewed on 11/17/23 at es included, but were not limited failure, hypertension (high nxiety and depression.							
	assessment, dated was cognitively in	nimum Data Set (MDS) 10/3/23, indicated the resident tact for daily decision making and lower body limitations and							
	had a self care per including bed mot toileting. Intervent	111/1/23, indicated the resident formance deficit with ADLs bility, eating, transfers, and ions included, but were not rith bed mobility, eating, ting as needed.							
	(ADON) on 11/17	Assistant Director of Nursing /23 at 9:35 a.m., indicated she ormation to provide.							
	This citation relate	es to Complaint IN00419836.							
	3.1-38(a)(3)(D) 3.1-38(a)(3)(E)								
⁼ 0684 SS=E Bldg. 00	applies to all trea facility residents. comprehensive a facility must ensu	a fundamental principle that tment and care provided to							

STATEME	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	ILDING	00	COMPLETED		
		155131	B. WING			11/20/	0/2023	
		-		STREET	ADDRESS, CITY, STATE, ZIP COD			
NAME OF 1	PROVIDER OR SUPPLIE	R		7935 C	CALUMET AVE			
MUNSTE	ER MED-INN			MUNS	TER, IN 46321			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX	(EACH DEFICIE	NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT	Ē	COMPLETION	
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE	
	professional stan	dards of practice, the						
	comprehensive p	erson-centered care plan,						
	and the residents	' choices.						
	Based on observat	ion, record review, and	F 06	584	Munster Med-Inn		12/04/202	
	interview, the facil	ity failed to ensure areas of			Annual Survey: 11/20/2023			
	bruising and scabb	ing were assessed and			Please accept the following as	the		
	-	on was applied to dry scaly feet			facility's credible allegation of			
		reviewed for skin conditions			compliance. This plan of			
	non-pressure relate	ed. The facility also failed to			correction does not constitute a	an		
	-	ere monitored for constipation			admission of guilt or liability by			
		reviewed for constipation.			facility and is submitted only in			
		, C, G, M, J, and H)			response to the regulatory			
	,,, _,, _	· · · · · · -/			requirement.			
	Findings include:				F684 Quality of Care			
	- manigo merader				What corrective action(s) will			
	1. On 11/15/23 at	10:26 a.m. and 3:00 p.m.,			be accomplished for those			
		served in their room in bed. A			residents found to have been			
		se was observed on the top of			affected by the deficient			
	their left hand.				practice;			
					Resident's M, K, N, H, and E-			
	On 11/16/23 at 9.2	6 a.m. and 11:28 a.m., the			Bruises were assessed, MD wa	as		
	bruising remained			notified. New orders were obtain				
					to monitor bruising.			
	The record for Rec	ident N was reviewed on			Resident G- New orders were			
		m. Diagnoses included, but			received to prevent future			
	-	, palliative care, dementia with			constipation.			
		ce, and peripheral vascular			Resident J'-s scabbed area wa			
	disease (PVD).	ee, and peripheral vasculai			addressed.	13		
	The Questerly Min	imum Data Set (MDS)			Resident's -C dry skin was			
	· ·	× ,			addressed.			
		8/15/23, indicated the resident			How the facility will identify			
	-	paired for daily decision			other residents having the			
	-	ent required extensive			potential to be affected by the	•		
	assistance for bed	mobility.			same deficient practice and			
					what corrective action will be			
		Plan related to the resident's			taken;			
	bruise.				All residents have the potential			
					be affected by the same allege	d		
	-	Observation form, dated			deficient practice.			
	11/14/23, indicated	the resident's skin was intact.			What measures will be put int	to		

STATEME	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLI	E CONSTRUCTION	(X3) DATE SU	JRVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING		COMPLE	ГED	
		155131	B. WING		11/20/2	20/2023	
NAME OF	PROVIDER OR SUPPLIE	ER		ET ADDRESS, CITY, STATE, ZIP O	COD		
				5 CALUMET AVE			
MUNSI	ER MED-INN		MUN	NSTER, IN 46321	<u>-</u>		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF COL	RRECTION	(X5)	
PREFIX	(EACH DEFICIE	NCY MUST BE PRECEDED BY FULL	PREFIX	CROSS-REFERENCED TO THE	SHOULD BE APPROPRIATE	COMPLETIC	
TAG	REGULATORY C	OR LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)		DATE	
	There was no docu	amentation about the resident's		place or what system	nic		
	bruise.			changes will be made	e to		
				ensure that the defici	ient		
	Interview with the	Assistant Director of Nursing		practice does not rec	ur;		
	on 11/17/23 at 2:0	3 p.m., indicated there was no		Nurses were re-educa	ited on:		
	additional docume	entation related to the resident's		Addressing and	assessing		
	bruising.			changes in skin condit	tion such as		
	-			bruises, obtaining orde			
	2. On 11/14/23 at	2:13 p.m., Resident E was		treatment, and implem			
		oom in bed and was wearing a		treatment.			
	hospital gown. La	rge areas of reddish/purple		Assistive clinical staff	were		
		erved to their bilateral forearms		educated on:			
		sident was not wearing geri		Notifying the nur	se of any		
		e arm coverings) at that time.		change in residents' s	-		
	U U	6 /		conditions.			
	On 11/15/23 at 2:4	15 p.m., the resident was		How the corrective a	ction(s)		
		oom seated in his wheelchair.		will be monitored to e			
		lressed and geri sleeves were in		deficient practice will			
	use.	8		recur, i.e., what quali			
				assurance programs	-		
	The record for Res	sident E was reviewed on		into place;	will be put		
		.m. Diagnoses included, but		Facility Angels/design	ee will		
		b, stroke, dementia with other		complete observation			
		ice, major depressive disorder,		10 residents 3 times p			
		y disease Stage 3. The resident		ensure areas of bruisi			
		gnosis of purpura (a rash of		or scabbed areas are			
		small blood vessels leaking		the nurse.			
	blood into the skir	-		Nurse Managers will r	oviow 10		
	blood into the skill	ı <i>)</i> .		residents Point of Car			
	The Quarterly Mir	nimum Data Set (MDS)		documentation weekly	· · ·		
		9/11/23, indicated the resident		residents with no bow			
		paired for daily decision					
		extensive assistance with bed		for 3 days or more are			
	U 1	erate assistance with transfers.		intervention for constig			
				Director of Nursing/de	-		
	A Corre Diana di t	1 6/26/22 and novigered		present a summary of			
		1 6/26/23 and reviewed on		to the Quality Assuran			
		the resident was at risk for		committee monthly for			
	~	ted to anticoagulant therapy		Thereafter, if determin	-		
		included, but were not limited		Quality Assurance cor			
	to, daily skin inspe	ection per facility protocol and		auditing and monitorin	ig will be		

	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155131	A. 1	MULTIPLE C BUILDING VING	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 11/20/2023	
	provider or supplief ER MED-INN	1		7935 C	ADDRESS, CITY, STATE, ZIP C CALUMET AVE TER, IN 46321	OD	
MUNST (X4) ID PREFIX TAG	SUMMARY (EACH DEFICIEN REGULATORY OF report abnormalities Observe/document/ adverse reactions of tinged or red blood dark or bright red b headaches, nausea, joint pain, lethargy, shortness of breath, changes in mental s sudden changes in v A Physician's Order resident was to rece medication) 75 mill A Physician's Order resident was to rece medication) 75 mill A Physician's Order resident was to wea at all times for skin could be removed f The Weekly Skin C indicated the reside concerns were noted Interview with the 4 (ADON) on 11/17/2 resident's bruises sh 3. On 11/14/23 at 1 observed in their ro bruise was observed	report as needed (PRN) f antiplatelet therapy: blood in urine, black tarry stools, lood in stools, sudden severe vomiting, diarrhea, muscle bruising, blurred vision, loss of appetite, sudden tatus, and significant or vital signs. c, dated 11/1/23, indicated the tive Plavix (an antiplatelet igrams (mg) one time a day. c, dated 11/15/23, indicated the r geri sleeves or long sleeves protection. The geri sleeves or hygiene. bbservation form, dated 11/9/23, mt's skin was intact and no d. Assistant Director of Nursing 23 at 2:30 p.m., indicated the would have been monitored. 0:39 a.m., Resident K was om in bed. A fading green				iould BE PPROPRIATE sent eting. oing. iic	(X5) COMPLETIC DATE
	11/17/23 at 9:49 a.r were not limited to, history of lung cance	nt K's left hand. dent K was reviewed on n. Diagnoses included, but muscle weakness, malaise, eer, bed confinement, and The resident was admitted to					

	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155131	(X2) MULTIPLE CC A. BUILDING B. WING	DNSTRUCTION 00	(X3) DATE SURVEY COMPLETED 11/20/2023			
	PROVIDER OR SUPPLIE	ËR	STREET ADDRESS, CITY, STATE, ZIP COD 7935 CALUMET AVE MUNSTER, IN 46321					
	1			I EIX, IN 40321				
(X4) ID PREFIX TAG	(EACH DEFICIE	Y STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE A DEFICIENCY)	HOULD BE	(X5) COMPLETIC DATE		
	the facility on 11/9	9/23.						
	The Admission M assessment was in	inimum Data Set (MDS) progress.						
		ursing assessment, dated lentify the bruising to the left						
	-	er, dated 11/10/23, indicated the s to be assessed weekly on y evening.						
	(MAR), indicated signed out as being	ication Administration Record the skin assessments were g completed on 11/10 and vas no documentation indicating ny bruises.						
	on 11/17/23 at 3:0	Assistant Director of Nursing 5 p.m., indicated the area of ident's left hand was not tored.						
	observed in their r were exposed and resident was obser soles of both feet a with the resident a	11:23 a.m., Resident C was oom in bed. The resident's feet elevated on a blanket. The ved with dry, scaly skin to the and along the arch. Interview t that time, indicated on ald put lotion on their feet and						
		:30 a.m., the resident was again , scaly skin to her feet.						
		28 a.m., 11:30 a.m., and 1:54 p.m., remained dry and scaly.						
	The record for Res	sident C was reviewed on						

STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE C	ONSTRUCTION	(X3) DATE SURVEY		
	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING	00	COMPLETED		
AND FLAN	OF CORRECTION	155131	B. WING	00	11/20/2023		
		100101					
NAME OF I	PROVIDER OR SUPPLIE	ER		ADDRESS, CITY, STATE, ZIP CALUMET AVE	COD		
MUNST	ER MED-INN			TER, IN 46321			
	1						
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CO			
PREFIX	(EACH DEFICIE	NCY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE		ETIC	
TAG		OR LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)	DATI	Έ	
		a.m. Diagnoses included, but					
		o, hemiplegia and hemiparesis					
		and paralysis) following a					
	stroke, type 2 diab	etes, and epilepsy.					
	The Quarterly Mir	nimum Data Set (MDS)					
		8/16/23, indicated the resident					
	,	tact and required extensive					
	assistance with per	-					
	The second sector and sector						
	to their feet.	o current order to apply lotion					
	The Weekly Skin	Observation form, dated					
		d the resident's skin was intact.					
	There was no docu	umentation related to the					
	resident's scaly fee	et.					
		Assistant Director of Nursing					
		/23 at 1:00 p.m., indicated lotion					
		applied to the resident's feet. 5.					
		p.m., on 11/15/23 at 10:48 a.m.					
	· ·	11/16/23 at 9:15 a.m. and 1:50					
	-	7/23 at 8:04 a.m. and 9:33 a.m.,					
		oserved in bed. At those times					
		ng thick toenails with dry scaly					
	skin on both feet.						
	The record for Res	sident G was reviewed on					
		.m. Diagnoses included, but were					
		ltiple sclerosis, vascular					
		epressive disorder, mood					
	-	ia, hammer toes for left and right					
		ormity, pain in the toes, fecal					
	-	ation, and anxiety.					
	The 9/14/23 Quart	erly Minimum Data Set (MDS)					
		ted the resident was severely					
		ion making and had short and					
	-	problems. The resident needed					
	1		1	1			

	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155131	(X2) MULTIPLE CC A. BUILDING B. WING	DNSTRUCTION 00	(X3) DATE SURVEY COMPLETED 11/20/2023			
	PROVIDER OR SUPPLIE	ËR	STREET ADDRESS, CITY, STATE, ZIP COD 7935 CALUMET AVE MUNSTER, IN 46321					
MUNST	ER MED-INN		WUNS	IER, IN 40321				
(X4) ID PREFIX TAG	(EACH DEFICIE	Y STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL DR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETIC DATE		
	extensive assist wi bed mobility and t with a 1 person ph hygiene, dressing frequently incontin bowel toileting pro- A Care Plan, revis resident had impai outer ankle. The ay treatment as per ou A Care Plan, initia resident was at risi immobility. The ay bowel regimen if n days. There were no Phy lotion for the resid feet. A Nurses' Note, da indicated at 12:45 to be lethargic. Th not open their eyes was 148/84, tempo was 101. The Phys orders to send the was cobtained. The a.m. The History and P 8/27/23, indicated was cholelithiasis cholecystitis (an in pain, and high gra- fecal impaction of	ith 2 person physical assist for oileting, and an extensive assist and eating. The resident was nent of bowel and was not on a ogram. ed on 6/30/23, indicated the ired skin integrity to the right pproaches were to render rders. ated on 9/1/23, indicated the k for constipation related to pproaches were to implement the no bowel movement every 3 ysician's Orders for any type of lent's dry scaly skin on their ated 8/27/23 at 1:26 a.m., a.m., the resident was observed eir name was called but they did s. The resident's blood pressure erature was 101.2, and the pulse sician was notified and new resident to the emergency room resident to the emergency room resident left the facility at 1:20 hysical from the hospital, dated the assessment of the resident (gallstones) with possible nflamed gallbladder), abdominal de constipation with massive 'sigmoid colon.						
	A Cat Scan (CT) o	of the pelvis without contrast,						

TATEME	NT OF DEFICIENCIES	V1) DROVIDED (CUDDI JED (CLIA	$(\mathbf{v}\mathbf{v})$		NSTRUCTION	(V2) DA	TE CUDVEV
	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	ì í			· · ·	TE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER		BUILDING	00	COMPLETED	
		155131	В.	WING		11/20/2023	
NAME OF	PROVIDER OR SUPPLIEF	-	_		ADDRESS, CITY, STATE, ZIP	COD	
MUNST	ER MED-INN			MUNST	ER, IN 46321		
X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CO	DRRECTION	(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE	SHOULD BE	COMPLETI
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
		ated high grade constipation					
		impaction of the sigmoid colon					
	in the rectum.						
	The resident returned	ed to the facility on 8/31/23.					
		dated 6/9/23, indicated					
	Docusate Sodium 5	0 milligrams/5 milliliters (ml),					
	-	a day. Polyethylene glycol					
		very morning for constipation					
	-	rams/15 ml, give 30 ml at					
	bedtime for constip	ation.					
	Physician's Orders,	dated 8/31/23, indicated					
	Senokot S oral table	et 8.6-50 milligrams (mg) (a					
	stimulant laxative),	give 2 tablets via the peg tube					
	every 24 hours as n	eeded for constipation.					
	The Bowel Movem	ent (BM) Record indicated the					
	resident had a smal	BM on 8/22, 2 small BM's on					
	8/23, no BM on 8/2	4 and 8/25 and 1 small BM on					
	8/26/23.						
	The BM Record inc	licated the resident had no BM					
	on 9/8, 9/9, and 9/1	0/23. There was no BM					
	recorded on 10/5, 1	0/6, 10/7, 10/29, 10/30, 10/31,					
	and 11/1/23.						
	The Medication Ad	ministration Record (MAR) for					
		23,10/2023 and 11/1-11/16/23,					
		ation of Senokot S oral tablet					
		d for constipation had not been					
	administered.						
	Interview with the s	Second Floor Unit Manager					
		at 8:45 a.m., indicated the					
		history of constipation and					
	-	ing should be done if there					
		ement. She was unaware the					
	resident's feet were	dry and scaly					

	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155131	(X2) MULTIPLE CC A. BUILDING B. WING	DNSTRUCTION 00	(X3) DATE SURVEY COMPLETED 11/20/2023			
	PROVIDER OR SUPPLIE	R	STREET ADDRESS, CITY, STATE, ZIP COD 7935 CALUMET AVE MUNSTER, IN 46321					
(X4) ID PREFIX TAG	SUMMARY (EACH DEFICIE	Ý STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL IR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORI (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE A DEFICIENCY)	IOULD BE	(X5) COMPLETIC DATE		
	indicated she put i Lactulose for the r days of no bowel r medication should The current 9/20/2 policy, provided b Nursing on 11/17/ residents who had considered for pha non-pharmacologi juice, or encourage taken into conside have a "normal" b hours without com be considered on a 6. During an interv 11/14/23 at 11:47 was a bruise to the they removed the p bruised area was of The record for Res 11/16/23 at 11:03 were not limited to pulmonary disease failure, major depu pressure, anxiety, supplemental oxyg The 9/29/23 Quart assessment, indica cognitively intact. as a resident and in anticoagulant med	 1, "Bowel Elimination Protocol" y the Assistant Director of 23 at 3:23 p.m., indicated no BM for 72 hours will be rmacological intervention or cal intervention, such as prune e increased fluids. It should be ration that some residents may owel pattern of greater than 72 stipation. Each resident should in individual basis. view with Resident M on a.m., the resident indicated there fir right outer hand. At that time, geri sleeve and the red/purple bserved. sident M was reviewed on a.m. Diagnoses included, but b, COPD (chronic obstructive c), anemia, chronic respiratory ressive disorder, high blood and dependence on gen. 						
	The Care Plan, rev	vised on $6/13/23$, indicated the						

OT A TEN (E)	TO DE DE LOUENOURS	W1) DROVIDER (CURPLIER / CLIA		NETRUCTION		CUDVEN	
	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CO		. ,	SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING	00	_	1PLETED 20/2023	
		155131	B. WING		11/20	/2023	
NAME OF	PROVIDER OR SUPPLIE	R		ADDRESS, CITY, STATE, ZIP	COD		
MUNICT							
MUNST	ER MED-INN		MUNS	FER, IN 46321			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CO		(X5)	
PREFIX	(EACH DEFICIE	NCY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION) CROSS-REFERENCED TO THE		COMPLETIC	
TAG		R LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)		DATE	
	-	tial/ actual impairment to skin					
		the use and side effects of the					
	-	ication. The approaches were to					
	document weekly	skin observations.					
	Physician's Orders	, dated 5/10/23, indicated geri					
		eves to be worn at all times for					
	skin protection.	eves to be worn at all times for					
	skin protection.						
	Physician's Orders	, dated 5/20/23, indicated					
		gulant medication) 2.5					
	milligrams (mg) t						
	The last weekly sk	in observation was dated					
	11/10/23 at 1:15 p	.m. and there were no bruises or					
	any other skin con	cerns indicated.					
		imentation in Nurses' Notes					
		23 regarding any bruising to their					
	right hand area.						
	Interview with the	Second Floor Unit Manager					
		at 8:45 a.m., indicated she was					
		ent had a bruise to the right					
	hand.	C C					
		UM on 11/17/23 at 3:20 p.m.,					
		was new and she asked the					
		got it and the resident indicated					
	it was from bumpi	ng the side rail while in bed.					
	7. On 11/14/23 at	10:45 a.m., Resident J was					
		in a wheelchair by the Nurses'					
		ne, there were 2 large scabbed					
		nt's face. One scab was located					
		and the other was on the right					
	side of the cheek.	and the other was on the light					
	side of the check.						
	The record for Resident J was reviewed on	ident J was reviewed on					
	11/16/23 at 3:03 p	.m Diagnoses included, but					
	1	6					

	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	Ê Í		INSTRUCTION		TE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER		BUILDING	00		APLETED
		155131	В. '	WING		11/20/2023	
NAME OF	PROVIDER OR SUPPLIER	-			ADDRESS, CITY, STATE, ZIP	COD	
MUNSI	ER MED-INN			MUNSI	ER, IN 46321		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CC		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE		COMPLETI
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
		stroke, Alzheimer's disease,					
	-	e sacral region, psychotic					
		ressive disorder, and					
	osteoarthritis.						
	The 10/22/23 Modi	fication of the Quarterly					
		(MDS) assessment, indicated					
		ely understood/understands					
		paired for decision making.					
		stage 3 pressure ulcer.					
	A Care Plan, revise	d on 11/15/23, indicated the					
		for complications related to					
		rity. The approaches were to					
	evaluate the skin an	d skin integrity.					
	The last Weekly Sk	in Assessment, completed on					
	11/15/23, indicated	there was no skin breakdown.					
	There was no docur	nentation regarding the					
	scabbed areas on th	e right cheek and above the					
	left eye.						
		nentation in Nursing Progress					
		3 through 11/16/23 regarding					
	the scabbed areas to	o the face.					
	Interview with the S	Second Floor Unit Manager					
		at 8:40 a.m., indicated she had					
		l areas were from their					
		ere was no documentation in					
	the record to reflect	that.					
	Interview with the S	Second Floor UM on 11/17/23					
	at 3:20 p.m., indicat	ted there was no documentation					
	_	ompleted of the scabbed areas					
		e. The UN indicated they have					
		ng, however, nothing was					
		11/14/23 at 10:25 a.m., a					
	reddish/ burgundy o	discoloration was observed on					
	Resident H's bilate		1				

TERS FO	R MEDICARE & MEDIC					OMB NO. 0938-0	
STATEME	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DAT	E SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER		JILDING	00	COMPLETED	
		155131	B. WI	NG			0/2023
NAME OF	PROVIDER OR SUPPLIEF	-			ADDRESS, CITY, STATE, ZIP (COD	
MUNST	ER MED-INN			MUNSI	FER, IN 46321		
X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CO	RRECTION	(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE		COMPLET
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	On $\frac{11}{16/23}$ at 10.7	25 a.m., the fading discoloration					
		ident's bilateral forearms.					
		aent 5 onatorar forearms.					
		dent H was reviewed on					
		n. Diagnoses included, but					
		chronic obstructive pulmonary					
	disease, hypertensio	on, and type 2 diabetes.					
	The Ouarterly Mini	mum Data Set (MDS)					
		$\frac{1}{26/23}$, indicated the resident					
		irment. The resident needed					
		e with bed mobility and					
	transfers.						
	The Weekly Skin C	Observation sheet, dated					
		the resident's skin was intact					
		ocumentation of bruising.					
	Interview with the	Assistant Director of Nursing					
		23 at 2:53 p.m., indicated she					
		it's bilateral forearm bruising to					
	the nurse and there	was now an order for the					
	bruising to be moni	tored.					
	A policy titled "Ski	n Condition Assessment &					
		e and Non-Pressure" received					
	e e	Assistant Director of Nursing					
		23 at 3:23 p.m., indicated:					
	"Non- pressure sk						
	(bruises/contusions	, abrasions, lacerations,					
		urgical wounds, etc.) Will be					
		g progress and signs of					
	complications or in	fection weekly"					
	This citation relates	to Complaints IN00418486					
	and IN00420643.	1					
	3.1-37(a)						
	5.1 57(4)				1		

ENTERS FOI STATEMEI	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MU	JLTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	î î	ILDING	00	COMP	LETED
		155131	B. WI	NG		11/20	
NAME OF	PROVIDER OR SUPPLIE	R			ADDRESS, CITY, STATE, ZIP COD		
	ER MED-INN				ALUMET AVE FER, IN 46321		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	DROVIDEDIS DI AN OF CODDECTIO	N	(X5)
PREFIX	(EACH DEFICIE)	NCY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD)	BE	COMPLETION
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION		TAG	CROSS-REFERENCED TO THE APPROF DEFICIENCY)	RIATE	DATE
0685	483.25(a)(1)(2)						
SS=D		es to Maintain Hearing/Vision					
Bldg. 00	§483.25(a) Vision and hearing						
U U		sidents receive proper					
		sistive devices to maintain					
	vision and hearin						
	if necessary, ass						
	§483.25(a)(1) In	making appointments, and					
	§483.25(a)(2) By						
	to and from the o	ffice of a practitioner					
	specializing in the	e treatment of vision or					
	hearing impairme	ent or the office of a					
	professional spec	cializing in the provision of					
	vision or hearing	assistive devices.					
	Based on record re	view and interview, the facility	F 06	585	Munster Med INN		12/04/202
	failed to ensure an	ed to ensure an Optometrist's recommendation eye drops was completed in a timely manner			Annual Survey: 11/20/202	3	
	for eye drops was						
		reviewed for communication			Please accept the following		
	and sensory. (Resi	dent 146)			facility's credible allegation	of	
					compliance. This plan of		
	Finding includes:				correction does not constitu		
					admission of guilt or liability	-	
	•	w on 11/14/23 at 2:49 p.m.,			facility and is submitted only	y in	
		ated she had seen the eye			response to the regulatory		
	-	new glasses were ordered, but			requirement.		
	she had not receive	ed them.			F685 Treatment /Devices t	0	
					Maintain Hearing/Vision		
		ident 146 was reviewed on			What corrective action(s)		
	-	m. Diagnoses included, but were			be accomplished for those		
		ertensive chronic kidney			residents found to have be	een	
		betes, end stage renal disease,			affected by the deficient		
	-	al dialysis, acute kidney failure,			practice;		
	repeated falls, and	edema.			Orders were received from	the	
					physician for eye drops for		
	-	rly Minimum Data Set (MDS)			resident 146.	_	
	· · · · ·	ted the resident was			How the facility will identify	-	
		The resident's vision was			other residents having the		
	I adequate with corr	ective lens. She had no oral	1		potential to be affected by	the	1

	NT OF DEFICIENCIES	x1) provider/supplier/clia identification number 155131	(X2) MULTIPLE CO A. BUILDING B. WING	DNSTRUCTION 00	(X3) DATE SURVEY COMPLETED 11/20/2023
	PROVIDER OR SUPPLIE ER MED-INN	R	7935 C	ADDRESS, CITY, STATE, ZIP COD ALUMET AVE FER, IN 46321	
-					
(X4) ID PREFIX TAG	(EACH DEFICIE)	STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	ATE (X5) COMPLETIC DATE
IAU	problems, weighed significant weight dialysis as a reside An Optometry Pro indicated the reside eyes. Recommend Refresh Plus Opht drop into both eyes The order was writ At that time, new g An Optometry Pro indicated the reside for both eyes. "The received eye drops medication order f Solution apply 1 d for indefinitely wa discussed with Soc Physician's Orderss Drops Advanced F 0.05-0.1-1-1 %, in times a day for dry Interview with the 11/17/23 at 3:20 p. the eye doctor in 4 Refresh eye drops script on a Physici	1 122 pounds, and has had a loss. The resident received nt. gress Note, dated 4/13/23, ent had mild dry eyes for both a new medication order of halmology Solution apply 1 s twice a day for indefinitely. ten and given to Social Service. glasses were not recommended. gress Note, dated 5/24/23, ent now had moderate dry eyes e patient states she never from the last visit." A new for Refresh Plus Ophthalmology rop into both eyes twice a day s written and given to and cial Service. , dated 5/24/23, indicated Eye Relief Ophthalmic Solution still 1 drop in both eyes two		same deficient practice and what corrective action will b taken; All facility residents requiring vision services have the pote to be affected by the same all deficient practice. What measures will be put i place or what systemic changes will be made to ensure that the deficient practice does not recur; Staff were educated on ensure optometry recommendations/follow up is completed timely. How the corrective action(st will be monitored to ensure deficient practice will not recur, i.e., what quality assurance programs will be into place; Social Service/designee will a weekly to see if any residents were seen by optometry, if so Unit Manager/designee will e recommendations are followed Director of Nursing /designee present a summary of the aud to the Quality Assurance committee monthly for 4 mon Thereafter, if determined by t Quality Assurance committee auditing and monitoring will b done quarterly and present quarterly at the QA meeting. Monitoring will be on going.	ntial leged nto ring s) the put audit s o the nsure ed. will dits ths. he s,
				Date by which systemic corrections will be complete	ed:

	NT OF DEFICIENCIES OF CORRECTION	x1) provider/supplier/clia identification number 155131	r í	JILDING	onstruction 00	COMP	: survey leted 1/2023
	provider or supplie ER MED-INN	R		7935 C	ADDRESS, CITY, STATE, ZIP COD ALUMET AVE TER, IN 46321		
(X4) ID PREFIX TAG	(EACH DEFICIE)	STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI/ DEFICIENCY)	ATE	(X5) COMPLETION DATE
					12/4/2023		
= 0686 SS=D Bldg. 00	Ulcer §483.25(b) Skin I §483.25(b)(1) Pre Based on the cor a resident, the fac (i) A resident rece professional stan pressure ulcers a pressure ulcers a pressure ulcers a pressure ulcers a condition demons unavoidable; and (ii) A resident with necessary treatm with professional promote healing, new ulcers from a Based on observati interview, the facil ulcers were covere ordered by the Phy were obtained time of 4 residents revie (Residents G and J Findings include: 1. On 11/14/23 at observed in bed. A observed with bloc bright red. There we	essure ulcers. nprehensive assessment of cility must ensure that- eives care, consistent with dards of practice, to prevent nd does not develop nless the individual's clinical strates that they were n pressure ulcers receives ent and services, consistent standards of practice, to prevent infection and prevent developing. on, record review, and ity failed to ensure pressure d securely with a bandage as sician and treatment orders ely for new pressure ulcers.	F 04	586	Munster Med-Inn Annual Survey: 11/20/2023 Please accept the following a facility's credible allegation of compliance. This plan of correction does not constitute admission of guilt or liability b facility and is submitted only i response to the regulatory requirement. F686 Treatment/Svcs to Prevent/Heal Pressure Ulcers What corrective action(s) wi be accomplished for those residents found to have bee affected by the deficient practice;	e an y the n	12/04/202

	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155131	(X2) MULTIPLE C A. BUILDING B. WING	ONSTRUCTION (X 00	(3) DATE SURVEY COMPLETED 11/20/2023
NAME OF	PROVIDER OR SUPPLI	ER		ADDRESS, CITY, STATE, ZIP COD	
MUNST	ER MED-INN			CALUMET AVE TER, IN 46321	
(X4) ID	SUMMAR	Y STATEMENT OF DEFICIENCIE	ID		(X5)
PREFIX	(EACH DEFICIE	ENCY MUST BE PRECEDED BY FULL	PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	
TAG	REGULATORY	OR LSC IDENTIFYING INFORMATION	TAG	CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	DATE
	11/16/23 at 9:15 a	a.m., 1:50 p.m., the resident was		Resident J's- treatment was	
		At those times, their feet were		immediately replaced.	
		irectly on the mattress and not		Resident G's feet were	
		oaded. The top right foot was		immediately off-loaded. Resider	nt
	-	ody scabs and the foot was		G's MD was notified, and orders	
	bright red.	· · · · · · · · · · · · · · · · · · ·		were obtained for newly identified	
	8			pressure ulcer.	-
	On 11/17/23 at 8.	04 a.m., the resident was		How the facility will identify	
		nd their feet were laying directly		other residents having the	
		nd not suspended or offloaded.		potential to be affected by the	
		e bandage observed to the right		same deficient practice and	
	foot dated 11/16/2			what corrective action will be	
	1001 dated 11/10/2	23.			
	During a wound t	reatment observation on		taken;	
	-	a.m., the wound care nurse was		All residents with pressure ulcer	
		ing the treatment for the right		have the potential to be affected	
	-			by the same alleged deficient	
		the old bandage from the right		practice.	
		s bright red with multiple		What measures will be put into	,
		d 2 dark purple sores were		place or what systemic	
		e right foot. One area was hard		changes will be made to	
	with a black scab	and the other area was open.		ensure that the deficient	
	T 1 10 D			practice does not recur;	
		sident G was reviewed on		Nurses were re-educated on the	;
		.m. Diagnoses included, but were		following:	
	,	lltiple sclerosis, vascular		Ensuring ordered	
	-	lepressive disorder, mood		preventative measure are in pla	ce
		ia, hammer toes for left and right		for at risk residents	
	-	formity, pain in the toes, fecal		Obtaining orders and	
	impaction, constig	pation, and anxiety.		implementing timely treatment for	or
				new skin conditions.	
		terly Minimum Data Set (MDS)		Notifying MD and resident	
		ated the resident was severely		responsible party of new skin	
	-	sion making and had short and		conditions.	
		y problems. The resident needed		Replacing treatment	
	extensive assist w	ith 2 person physical assist for		dressings that are soiled or	
	bed mobility and	toileting, and an extensive assist		detached from wound timely.	
	with a 1 person pl	hysical assist for personal		Assistive staff were re-educated	
		and eating. The resident was		on:	
		nent of bowel and was not on a		Notifying the nurse	
	bowel toileting pr			immediately when a treatment h	as

	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE C A. BUILDING	ONSTRUCTION		FE SURVEY IPLETED
		155131	B. WING	<u></u>	-	20/2023
NAME OF	PROVIDER OR SUPPLIE	ER		ADDRESS, CITY, STATE, ZIP CO	D	
MUNST	ER MED-INN			TER, IN 46321		
(X4) ID	SUMMARY	Y STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRI	ECTION	(X5)
PREFIX	(EACH DEFICIE	NCY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE AP	OULD BE PROPRIATE	COMPLETIC
TAG	REGULATORY C	OR LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)		DATE
				become soiled or detacl	hed from	
		ed on $6/30/23$, indicated the		wound.		
	-	red skin integrity to the right		How the corrective act		
		pproaches were to render		will be monitored to en		
	treatment as per or	rders.		deficient practice will r		
				recur, i.e., what quality		
		servation, dated 11/14/23 at 12:12		assurance programs w	vill be put	
	-	en lesions on the left and right		into place;		
		new. Wound care was being		Wound nurse/designee		
	provided.			randomly audit 10 reside		
				identified to be at risk fo		
		ation Assessment, dated		breakdown or with exist	-	
		d the right lateral foot was		breakdown to ensure sk		
		eep tissue injury that measured		conditions are documen		
) by 8 cm. There was 75% of		orders obtained, and tre	atments	
	epithelial (pale pir	nk or red tissue.		are in place per orders.		
				Director of Nursing/desi	-	
	-	e injury to the right lateral foot		present a summary of th		
	was resolved on 8/	/3/23.		to the Quality Assurance		
	DI CLOI			committee monthly for 4		
	-	s, dated 5/24/23, indicated to		Thereafter, if determined	-	
	suspend or offload	l heels while in bed.		Quality Assurance com		
	Dhusisian's Ordens	s, dated 11/16/23, indicated		auditing and monitoring		
		al foot with wound cleanser or		done quarterly and pres		
	e	ly an Adaptic bandage, and		quarterly at the QA mee Monitoring will be on go	-	
		ssing every day shift on		Date by which systemi	•	
		day, and Friday. May see the		corrections will be con		
	wound doctor.	ady, and I fiddy. Whay see the		12/4/2023	ipieteu.	
	would dootor.			12/4/2023		
	Interview with the	Second Floor Unit Manager on				
		.m., indicated the resident's heels				
	should be offloade					
	Interview with the	Wound Nurse on 11/17/23 at				
		ed while she was changing the				
		te's bandage yesterday and				
		Octor had left, the CNA				
		d indicated she needed to look				
		ht foot. The Wound Nurse				
		,				

STATEME	NT OF DEFICIENCIES	V1) DROVIDER/SUDDLIER/CLIA	(22) 1	AULTIPLE CO	NETRUCTION	(Y2) DA	TE CUDVEV
	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	ì í			(X3) DATE SURVEY COMPLETED	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER		BUILDING	00		
		155131	В. V	VING			/20/2023
NAME OF	PROVIDER OR SUPPLIER				DDRESS, CITY, STATE, ZIP	COD	
ALINIOT							
MUNSI	ER MED-INN			MUNST	ER, IN 46321		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CO	RRECTION	(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE	SHOULD BE	COMPLETI
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
		he first time she was made					
		right foot had open areas.					
		had just left and did not					
		owever, he had treated this					
		ound Doctor will assess the					
		xt week during his rounds.					
		should be suspended or					
		bed. There were no further					
	orders.						
	2 O_{π} 11/17/22 at 0	:11 a.m., Resident J was					
		e resident was just put back					
		At that time, the Wound Nurse					
		e the resident's bandage to the					
		er coccyx. The Wound Nurse					
	-	nt's incontinent brief which					
		ine and there was no bandage					
		re ulcer. The pressure ulcer					
	was red in color wit						
	The record for Resi	dent J was reviewed on					
	11/16/23 at 3:03 p.r	n Diagnoses included, but					
		stroke, Alzheimer's disease,					
	-	e sacral region, psychotic					
	disorder, major dep	ressive disorder, and					
	osteoarthritis.						
	The 10/22/23 Modi	fication of the Quarterly					
		(MDS) assessment, indicated					
		ely understood/understands					
		paired for decision making.					
		stage 3 pressure ulcer.					
	The Care Plan. revi	sed on 6/20/23, indicated the					
		ure ulcer to the sacral area.					
	-	re to administer treatments as					
	**	r for effectiveness, and					
		ensure it was intact and					
		ose dressings to the treatment					
	nurse.	-					

	F OF HEALTH AND HU R MEDICARE & MEDIC						FORM APPROVED OMB NO. 0938-039
STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	ì í	LTIPLE CO LDING	ONSTRUCTION	(X3) DA	TE SURVEY MPLETED
	or conduction	155131	B. WIN		<u></u>		20/2023
NAME OF F	PROVIDER OR SUPPLIE	R		STREET ADDRESS, CITY, STATE, ZIP COD 7935 CALUMET AVE			
MUNSTE	R MED-INN			MUNSTER, IN 46321			
(X4) ID				PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUL)		(X5)	
PREFIX TAG		NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	P	REFIX TAG	CROSS-REFERENCED TO THE APPR DEFICIENCY)		COMPLETION DATE
	Physician's Ordens	dated 11/16/22 indicated					
	-	, dated 11/16/23, indicated h normal saline, apply collagen,					
		m dressing every day shift on					
		ay, and Friday and as needed.					
	The last documente	ed Wound Measurement was					
		e Stage 3 pressure ulcer					
		meters (cm) by 1.4 cm by 1.0 cm.					
		6 slough (necrotic tissue) 40% and 30% other viable tissues)					
	-						
	The wound progress was exacerbated due to the patient being non-compliant with wound care and						
	resisting offloading	-					
	A Nurses' Note, da	ted 11/17/23 at 6:54 a.m.,					
		ent was gotten up out of bed					
	-	neir request. The resident was					
	sitting up in the wh	eelchair by nurses station.					
	Interview with the	Wound Nurse on 11/17/23 at					
		d she was unaware the pressure					
	ulcer had no banda	ge over it.					
	The current and 9/1	1/20 "Skin Condition					
		onitoring Pressure and Non					
		rovided by the Assistant					
		g on 11/17/23 at 3:23 p.m.,					
		ulcers will be assessed and veekly by the licensed nurse					
		the resident's clinical record.					
		ere applied to pressure ulcers,					
	-	inds shall include the date of					
	the licensed nurse	who performed the procedure.					
	This citation relate	s to Complaint IN00420643.					
	3.1-40(a)(2)						

85IL11

Facility ID: 000056

If continuation sheet

Page 29 of 49

	T OF DEFICIENCIES	,	ER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION		
1110012111	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING	00	COMPLETED
		155131	B. WING		11/20/2023
NAME OF F	PROVIDER OR SUPPLIE	ER		ADDRESS, CITY, STATE, ZIP COD	
MUNSTE	R MED-INN			CALUMET AVE TER, IN 46321	
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID		(X5)
PREFIX		NCY MUST BE PRECEDED BY FULL	PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION	TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	DATE
F 0687	483.25(b)(2)(i)(ii)		mo		Diffe
SS=D	Foot Care				
Bldg. 00	-	at aara			
Blug. 00	§483.25(b)(2) Fo				
	To ensure that residents receive proper treatment and care to maintain mobility and				
		3			
	-	the facility must:			
	(i) Provide foot care and treatment, in				
	accordance with professional standards of				
		luding to prevent			
		m the resident's medical			
	condition(s) and				
		assist the resident in making			
		h a qualified person, and			
		nsportation to and from such			
	appointments.				
		ion, record review, and	F 0687	Munster Med INN	12/04/202
		lity failed to ensure dependent		Annual Survey: 11/20/2023	
		foot care and had routine visits			
	-	elated to long and thick toenails		Please accept the following as	s the
		ts reviewed for ADL's. (Resident		facility's credible allegation of	
	G)			compliance. This plan of	
				correction does not constitute	
	Finding includes:			admission of guilt or liability by	
				facility and is submitted only in	ו ו
	On 11/14/23 1:52	p.m., on 11/15/23 at 10:48 a.m.		response to the regulatory	
	and 3:15 p.m., on	11/16/23 at 9:15 a.m. and 1:50		requirement.	
	p.m., and on 11/17	7/23 at 8:04 a.m. and 9:33 a.m.,		F687 Foot Care	
	Resident G was of	oserved in bed. At those times		What corrective action(s) wil	1
	the resident had lo	ng thick toenails with dry scaly		be accomplished for those	
	skin on both feet.			residents found to have beer	n
				affected by the deficient	
	The record for Res	sident G was reviewed on		practice;	
	11/15/23 at 3:32 p	.m. Diagnoses included, but were		Resident G was added to the	
	-	ltiple sclerosis, vascular		facilities next podiatry visit list	.
		epressive disorder, mood		How the facility will identify	
	-	ia, hammer toes for left and right		other residents having the	
		ormity, pain in the toes, fecal		potential to be affected by th	e
	-	ation, and anxiety.		same deficient practice and	-
	1, comotip	,,		what corrective action will be	e
	The 9/14/23 Quart	erly Minimum Data Set (MDS)		taken;	-

	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE C A. BUILDING	onstruction (X3) DATE SURVEY COMPLETED
		155131	B. WING		11/20/2023
	PROVIDER OR SUPPLIEI	ł	7935 0	ADDRESS, CITY, STATE, ZIP COD CALUMET AVE	
MUNST	ER MED-INN		MUNS	TER, IN 46321	
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX		ICY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATI DEFICIENCY)	
TAG		R LSC IDENTIFYING INFORMATION ed the resident was severely	TAG	Bia teliate 17	DATE
		on making and had short and		All facility residents requiring podiatry services have the	
	-	problems. The resident needed		potential to be affected by the	
		h 2 person physical assist for		same alleged deficient practice	
		ileting, and an extensive assist		What measures will be put int	
	-	vsical assist for personal		place or what systemic	•
		nd eating. The resident was		changes will be made to	
		ent of bowel and was not on a		ensure that the deficient	
	bowel toileting pro			practice does not recur;	
		-		Staff were educated to notify th	e
	A Podiatry Exam n	ote, dated 6/21/23, indicated the		nurse and/or social service of a	iny
	resident's toenails v	vere reduced in length and		resident in need of foot care so	
	thickness to 3 mm	(millimeters). The next exam was		that they may be added to the	
	to be as medically i	necessary but no sooner than		podiatry list.	
	60 days.			How the corrective action(s)	
				will be monitored to ensure the	e
		Assistant Director of Nursing		deficient practice will not	
		p.m., indicated the resident		recur, i.e., what quality	
		he hospital when the		assurance programs will be p	ut
	-	last, as she was on the 60 day		into place;	
	recall list to be seen	n on 11/21/23.		Social Service/designee will au	
	T			weekly to ensure new admissio	
		Second Floor Unit Manager on		are offered podiatry services an	10
		n., indicated they trimmed the vith a pair of large clippers.		any resident with need for foot	oit
	resident s toenans v	vitil a pair of large cuppers.		care is added to the podiatry vi list.	SIL
	This citation relates	s to Complaint IN00418486.		Administrator /designee will	
				present a summary of the audit	is l
	3.1-47(a)(7)			to the Quality Assurance	~
				committee monthly for 4 month	s.
				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	

	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155131	(X2) MULTIPLE CC A. BUILDING B. WING	00	COMI	e survey pleted 0/2023
	PROVIDER OR SUPPLIE	R	7935 C	ADDRESS, CITY, STATE, ZIP C ALUMET AVE	COD	
MUNSTE	R MED-INN		MUNST	FER, IN 46321		
(X4) ID PREFIX TAG	(EACH DEFICIE	Y STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE / DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
= 0690 SS=D Bldg. 00	§483.25(e) Incon §483.25(e)(1) The resident who is of bowel on admiss assistance to ma or her clinical con that continence is §483.25(e)(2)For incontinence, bas comprehensive a ensure that- (i) A resident who an indwelling cat unless the reside demonstrates that necessary; (ii) A resident who indwelling cathet one is assessed as soon as possi- clinical condition catheterization is (iii) A resident who receives appropri- to prevent urinary restore continence, bas comprehensive a ensure that a resi- bowel receives a	e facility must ensure that ontinent of bladder and ion receives services and intain continence unless his ndition is or becomes such is not possible to maintain. The a resident with urinary sed on the resident's assessment, the facility must on the facility without heter is not catheterized ent's clinical condition at catheterization was o enters the facility with an er or subsequently receives for removal of the catheter ble unless the resident's demonstrates that				

	OR MEDICARE & MEDIC	X1) PROVIDER/SUPPLIER/CLIA	(X2) MI II TID	LE CONSTRUCTION		MB NO. 0938-039 E SURVEY
	NOF CORRECTION	IDENTIFICATION NUMBER	A. BUILDIN		. ,	LETED
ND FLAN	OF CORRECTION	155131	B. WING	00)/2023
		155131	B. WING		—	5/2023
JAME OF	PROVIDER OR SUPPLIE	R		REET ADDRESS, CITY, STATE, ZIP C	COD	
ALINGT	ER MED-INN			35 CALUMET AVE JNSTER, IN 46321		
10131			IVIC	JNSTER, IN 40321		
X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF COR	RECTION	(X5)
REFIX	(EACH DEFICIE)	NCY MUST BE PRECEDED BY FULL	PREF	IX (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE A	HOULD BE APPROPRIATE	COMPLETION
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION	TA			DATE
	function as possi	ble.				
	Based on observation	ion, record review, and	F 0690	Munster Med-Inn		12/04/2023
	interview, the facil	ity failed to ensure a suprapubic		Annual Survey: 11/20)/2023	
	foley (urinary) cath	neter bag not on the floor and				
	catheter care was c	completed as ordered by the		Please accept the follo	wing as the	
	Physician for 1 of	1 residents reviewed for		facility's credible allega	ation of	
	catheters. (Residen	it 12)		compliance. This plan		
				correction does not co		
	Finding includes:			admission of guilt or lia	ability by the	
	-			facility and is submitte	•••	
	On 11/14/23 at 11:	09 a.m. and 2:47 p.m., and on		response to the regula	•	
		m. and 10:15 a.m., Resident 12		requirement.	,	
	was observed in be	ed. At those times, the foley		F690 Bowel/Bladder		
		ng on the side of the bed,		Incontinence, Cathete	er. UTI	
	-	vas touching the floor.		What corrective actio		
	, 8	8		be accomplished for		
	On 11/16/23 at 11:	30 a.m., the resident was		residents found to ha		
		NA 1 was asked to remove his		affected by the deficie		
		e stoma site of the supra pubic		practice;		
		around the catheter was dark		Resident 12's catheter	was	
		over. The catheter bag was		positioned off the floor		
	observed resting on the floor.			catheter care was rend		
	observed resting of			immediately.		
	On 11/17/23 at 7.4	5 a.m. and 8:26 a.m., the resident		How the facility will it	lontify	
		ed. At that time, the foley		other residents havin	-	
	catheter bag was o	-		potential to be affected	-	
	cameter bag was 0			same deficient practic	-	
	On 11/17/23 at 8.4	3 a.m., RN was asked to observe		what corrective action		
		pubic ostomy site. The RN		taken;		
	-	and the same brown crusty		All residents with indw	elling	
		d around the stoma.		catheters have the pot	-	
		a arouna me stoma.		affected by the same a		
	Interview with DN	1 at that time, indicated it was		deficient practice.	alleyeu	
		ibility to provide catheter care		What measures will b	o put into	
	for his suprapubic				-	
	for his suprapuble			place or what system		
	The record for D	ident 12 was reviewed on		changes will be made		
				ensure that the defici		
		m. The resident was admitted to		practice does not rec		
		23 from the hospital.		Staff were re-educated		
	Diagnoses include	d, but were not limited to, type		Ensuring cathete	r care	

STATEME	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MUL	TIPLE CO	ONSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUIL		00	· /	LETED
		155131	B. WING		<u></u>		/2023
			<u> </u>	STREET /	ADDRESS, CITY, STATE, ZIP COD		
NAME OF 1	PROVIDER OR SUPPLIE	ÜR.			ALUMET AVE		
MUNSTE	ER MED-INN				FER, IN 46321		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIE	NCY MUST BE PRECEDED BY FULL	PH	REFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI	ATF	COMPLETION
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	2 diabetes, Parkins	son's disease, stroke, dementia			orders are in place and cathe	ter	
	with other behavio	oral disturbance, urinary tract			care is rendered as per order	s.	
	infections, obstruc	ctive uropathy, chronic kidney			Ensuring catheter drain	age	
	disease, and major	depressive disorder.			bag/tubing are positioned off	the	
					floor		
	The Quarterly Mir	nimum Data Set (MDS)			How the corrective action(s))	
	assessment, dated	10/9/23, indicated the resident			will be monitored to ensure	the	
	was moderately in	paired for decision making and			deficient practice will not		
	had no behaviors.	The resident had an indwelling			recur, i.e., what quality		
	foley catheter and	received an antipsychotic,			assurance programs will be	put	
	antidepressant, and	d antiplatelet medications.			into place;		
					Nurse managers will audit 2		
	A Care Plan, revis	ed on 11/9/23, indicated the			residents with catheters 2 tim	es	
	resident had a urin	ary catheter for neurogenic			per week to ensure catheter of	care	
	bladder.				is rendered per orders and		
					catheter is positioned off the	floor.	
	Physician's Orders	, dated 10/2/23, indicated			The Director of Nursing/desig	nee	
	catheter care every	v shift.			will present a summary of the	•	
					audits to the Quality Assuran	ce	
	-	, dated 11/13/23, indicated			committee monthly for 4 mon	ths.	
		e 16 French, balloon size 10			Thereafter, if determined by t	he	
	milliliters (ml).				Quality Assurance committee	,	
					auditing and monitoring will b	е	
		ministration Record (TAR)			done quarterly and present		
	indicated foley cat	h care was signed out as being			quarterly at the QA meeting.		
	completed 11/1-11	/16/23.			Monitoring will be on going.		
					Date by which systemic		
		Second Floor Unit Manager on			corrections will be complete	ed:	
		.m., indicated the foley catheter			12/4/2023		
	-	on the floor and the nurses					
	were responsible to	o provide catheter care.					
	3.1-41(a)(2)						
0695	483.25(i)						
S=D	. /	heostomy Care and					
ldg. 00	Suctioning	-					1
-	•	iratory care, including					1
		re and tracheal suctioning.					
	-	ensure that a resident who					

Event ID: 85IL11

Facility ID: 000056

If continuation sheet Page 34 of 49

	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155131	(X2) MULTIPLE C A. BUILDING B. WING	CONSTRUCTION C	X3) DATE SURVEY COMPLETED 11/20/2023
	PROVIDER OR SUPPLIE	R	7935 (ADDRESS, CITY, STATE, ZIP COD CALUMET AVE STER, IN 46321	
-	1				
(X4) ID		Y STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	(X5)
PREFIX		NCY MUST BE PRECEDED BY FULL	PREFIX	CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	
TAG		R LSC IDENTIFYING INFORMATION	TAG		DATE
	needs respiratory	_			
	-	re and tracheal suctioning,			
		care, consistent with			
		idards of practice, the person-centered care plan,			
		als and preferences, and			
	483.65 of this sul	-			
		ion, record review, and	F 0695	Munster Med INN	12/04/2023
		lity failed to ensure oxygen was	1 0095	Annual Survey: 11/20/2023	12/04/2023
		rate for 1 of 2 residents		Annual Survey. 11/20/2025	
	reviewed for oxyg			Please accept the following as t	the
				facility's credible allegation of	
	Finding includes:			compliance. This plan of	
	6			correction does not constitute a	n
	During an intervie	w with Resident M on 11/14/23		admission of guilt or liability by	
	-	resident indicated they wore		facility and is submitted only in	
		e. The oxygen flow rate was set		response to the regulatory	
	at 2.5 liters per mi			requirement.	
				F695 Respiratory/Tracheostor	ny
	On 11/15/23 at 10:	:09 a.m., and 2:30 p.m., the		Care and Suctioning	
		ved wearing oxygen via nasal		What corrective action(s) will	
	cannula. The oxyg	en flow rate was set at 3 liters		be accomplished for those	
	per minute.			residents found to have been	
				affected by the deficient	
		sident M was reviewed on		practice;	
		a.m. Diagnoses included, but		Resident M- Oxygen flow rate v	vas
		o, COPD (chronic obstructive		immediately corrected.	
		e), anemia, chronic respiratory ressive disorder, high blood		How the facility will identify	
		and dependence on		other residents having the	
	supplemental oxyg	-		potential to be affected by the same deficient practice and	
	supplemental oxyg	<u>zen.</u>		what corrective action will be	
	The 9/29/23 Quart	erly Minimum Data Set (MDS)		taken;	
		ted the resident was		All residents receiving oxygen	
	· · · · · · · · · · · · · · · · · · ·	The resident received oxygen		have the potential to be affected	d
		n the last 7 days she received		by the same alleged deficient	
	an anticoagulant m	-		practice.	
	_			What measures will be put int	o
	A Care Plan, revis	ed on 10/23/23, indicated the		place or what systemic	
	resident had oxyge	en therapy due to the diagnosis		changes will be made to	

	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155131	(X2) MULTIPLE C A. BUILDING B. WING	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 11/20/2023	COMPLETED	
	PROVIDER OR SUPPLIE	R	STREET 7935 C MUNS				
(X4) ID PREFIX TAG	(EACH DEFICIE	' STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROI DEFICIENCY))N		
	of COPD. Physician's Orders via nasal cannula, continuously. Interview with the 11/17/23 at 8:40 a.	, dated 4/6/23, indicated oxygen administer at 2 liters per minute Second Floor Unit Manager on .m., indicated the resident's re been set at 2 liters per		 ensure that the deficient practice does not recur; Staff were re-educated on: Ensuring a physician is obtained/in-place for oxy Oxygen is administer the correct liter flow rate. Oxygen tubing is chat and labeled appropriately. How the corrective action will be monitored to ensure deficient practice will not recur, i.e., what quality assurance programs will linto place; Nurse Managers will audit fresidents with oxygen 2 tim week to ensure oxygen is in and set at the appropriate for rate. Director of Nursing/designed present a summary of the ato the Quality Assurance committe auditing and monitoring will done quarterly and present quarterly at the QA meeting Monitoring will be on going Date by which systemic corrections will be completed a summary of the atom and set at the appropriate for the Quality Assurance committer the operation of the atom and present a summary of the atom and the present and present a summary of the atom and the set of the quality Assurance committer the the quarterly and present quarterly at the QA meeting Monitoring will be on going Date by which systemic corrections will be completed the present a summary of the set of the quarterly at the qA meeting Monitoring will be on going Date by which systemic corrections will be completed the present a summary for the set of the quarterly at the qA meeting Monitoring will be on going Date by which systemic corrections will be completed the present as th	order gen. ed at nged (s) re the be put 5 nes per n place flow ee will audits onths. y the ee, I be		

Facility ID: 000056

10056 If con

If continuation sheet

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	NT OF DEFICIENCIES OF CORRECTION	x1) provider/supplier/clia identification number 155131	(X2) MULTIPLE C A. BUILDING B. WING	ONSTRUCTION	X3) DATE SURVEY COMPLETED 11/20/2023
NAME OF	PROVIDER OR SUPPLIE	R		ADDRESS, CITY, STATE, ZIP COD CALUMET AVE	
MUNSTI	ER MED-INN		MUNS	TER, IN 46321	
(X4) ID PREFIX	(EACH DEFICIE)	STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATI DEFICIENCY)	
TAG		R LSC IDENTIFYING INFORMATION	TAG	DEFICIENCE	DATE
⁻ 0698 SS=D Bldg. 00	require dialysis re consistent with pr practice, the com care plan, and the preferences. Based on observati interview, the facil resident received th	is. ensure that residents who eceive such services, rofessional standards of prehensive person-centered e residents' goals and ion, record review, and ity failed to ensure a dialysis he correct nutritional of 1 residents reviewed for	F 0698	Munster Med-Inn Annual Survey: 11/20/2023 Please accept the following as facility's credible allegation of	12/04/2023 the
	p.m., 11/15/23 at 2 p.m., there was a c supplement on Res	146) servations on 11/14/23 at 2:50 2:30 p.m., and 11/16/23 at 3:10 ontainer of Boost nutritional sident 146's over bed table. resident on 11/14/23 at 2:50		compliance. This plan of correction does not constitute a admission of guilt or liability by 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	the
	p.m., indicated she Thursdays, and Sat was given to her fr facility. She indic day.	e goes to dialysis on Tuesdays, turdays. The Boost supplement rom the nursing staff at the cated she gets them two times a		affected by the deficient practice; Resident 146- Ensure supplem was immediately removed from resident's bedside. The dialysis dietician was contacted, and ne	ent ; ;
	observed eating br	6 a.m., the resident was eakfast. At that time, there were Boost nutritional supplement ble.		orders were obtained for boost supplement per resident preference. How the facility will identify other residents having the	
	11/16/23 at 1:25 p. not limited to, hyp- disease, type 2 dial	ident 146 was reviewed on m. Diagnoses included, but were ertensive chronic kidney betes, end stage renal disease, al dialysis, acute kidney failure, edema.		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 b	

STATEME	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE C	ONSTRUCTION	(X3) DATI	E SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER 155131	A. BUILDING B. WING	00		PLETED D /2023
NAME OF	PROVIDER OR SUPPLIE	ER		ADDRESS, CITY, STATE, ZIP (ALUMET AVE	COD	
MUNST	ER MED-INN		MUNS	TER, IN 46321		
(X4) ID PREFIX TAG	(EACH DEFICIE	Y STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL DR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE DEFICIENCY)	RRECTION SHOULD BE APPROPRIATE	(X5) COMPLETION DATE
	The 9/6/23 Quarte assessment, indica cognitively intact. adequate with corn problems, weighed significant weight dialysis as a reside The Care Plan, rev resident required of The approaches w supplement of Nep a day. Physician's Orders house supplement day. Physician's Orders dialysis every Tue Interview with the 11/17/23 at 8:45 a	rly Minimum Data Set (MDS) ted the resident was The resident's vision was rective lens. She had no oral d 122 pounds, and has had a loss. The resident received		affected by the same a deficient practice. What measures will be place or what system changes will be made ensure that the deficien practice does not reconstruct Nursing staff were re- providing supplements physician orders. How the corrective are will be monitored to a deficient practice will recur, i.e., what quality assurance programs into place; Nurse Managers will a dialysis residents bein administration supplere times per week to ensi appropriate suppleme provided. The Director of Nursin will present a summar audits to the Quality A committee monthly for Thereafter, if determin Quality Assurance cor auditing and monitorin done quarterly and pro- quarterly at the QA me Monitoring will be on g Date by which system corrections will be con-	be put into hic e to ient cur; -educated on s as per ction(s) ensure the I not ty will be put audit 2 bg ments 2 sure int is ng/designee ty of the ssurance r 4 months. hed by the mmittee, ng will be esent eeting. going. mic	
0757 SS=D Bldg. 00	483.45(d)(1)-(6) Drug Regimen is Drugs	Free from Unnecessary				

	NT OF DEFICIENCIES OF CORRECTION	x1) provider/supplier/clia identification number 155131	r í	JILDING	DNSTRUCTION 00	CON	(X3) DATE SURVEY COMPLETED 11/20/2023	
	provider or supplie ER MED-INN	R		7935 C	ADDRESS, CITY, STATE, ZIP COD CALUMET AVE TER, IN 46321			
(X4) ID PREFIX TAG	(EACH DEFICIE REGULATORY O	STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROF DEFICIENCY)		(X5) COMPLETIC DATE	
	Each resident's of from unnecessar drug is any drug §483.45(d)(1) In duplicate drug the §483.45(d)(2) Fo §483.45(d)(3) Wi or §483.45(d)(3) Wi or §483.45(d)(4) Wi for its use; or §483.45(d)(5) In consequences w should be reduce §483.45(d)(6) An reasons stated in (5) of this section Based on record re failed to manage n holding blood pres days and checking to the administration medications with H 1 of 5 residents rev medications. (Resi Finding includes: The record for Res 11/16/23 at 1:25 p not limited to, hyp disease, type 2 dia	excessive dose (including erapy); or r excessive duration; or thout adequate monitoring; thout adequate monitoring; thout adequate indications the presence of adverse hich indicate the dose d or discontinued; or y combinations of the paragraphs (d)(1) through view and interview, the facility redications appropriately related sure medications on dialysis blood pressure and pulse prior on of blood pressure Physician ordered parameters for riewed for unnecessary dent 146) ident 146 was reviewed on m. Diagnoses included, but were ertensive chronic kidney betes, end stage renal disease, al dialysis, acute kidney failure,	F 0'	757	Munster Med-Inn Annual Survey: 11/20/23 Please accept the following facility's credible allegation compliance. This plan of correction does not constitu admission of guilt or liability facility and is submitted only response to the regulatory requirement. What corrective action(s) be accomplished for those residents found to have be affected by the deficient practice; Resident 146's- physician v	of tte an y by the y in will e een	12/04/202	

	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155131	(X2) MULTIPLE (A. BUILDING B. WING	construction (x 00	(X3) DATE SURVEY COMPLETED 11/20/2023	
NAME OF	PROVIDER OR SUPPLIE	ER		T ADDRESS, CITY, STATE, ZIP COD		
MUNSTI	ER MED-INN			STER, IN 46321		
(X4) ID	SUMMARY	Y STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX	(EACH DEFICIE	NCY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	COMPLETIC	
TAG	REGULATORY C	OR LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)	DATE	
	The 9/6/23 Quarte	rly Minimum Data Set (MDS)		notified and clarification was received for blood pressure		
	-	ited the resident was		parameters and medications to b	~	
	· · · · · · · · · · · · · · · · · · ·	The resident's vision was				
		rective lens. She had no oral		held on dialysis days. Orders we	re	
	-	d 122 pounds, and has had a		updated.		
		loss. The resident received		How the facility will identify		
				other residents having the		
	dialysis as a reside			potential to be affected by the same deficient practice and		
	The Core Dien rev	vised on 10/27/23, indicated the		-		
		lialysis related to renal failure.		what corrective action will be		
	resident required c	narysis related to renar failure.		taken;		
	Dharaitain da Ondana			All facility residents with		
		s, dated 8/29/23, indicated		medication parameters have the		
	dialysis every Tue	sday, Thursday, and Saturday.		potential to be affected by the		
	Dhandada ya Ondana			same alleged deficient practice.		
		s, dated 5/23/23, indicated		What measures will be put into	1	
		dication used to lower the blood		place or what systemic		
	· ·	igrams (mg), give 1 tablet three		changes will be made to		
	times a day.			ensure that the deficient		
	DI · · · O I			practice does not recur;		
		s, dated 7/6/23, indicated		Nurses were in-serviced on		
		ication used to lower the blood		following blood pressure		
	-	ease the heart rate) 3.125 mg,		parameters as ordered before		
		morning at bedtime for high		administering medication.		
	-	ay hold the morning dose on		Nurses were in-serviced on hold	ing	
	Tuesdays, Thursda	ays, and Saturdays for dialysis.		mediations as per		
	Dhandada ya Ondana			orders/administering medication	5	
		s, dated 9/16/23, indicated hold dications on Dialysis days in		per parameters.		
	-			How the corrective action(s)		
		Tuesday, Thursday, and		will be monitored to ensure the	<u>}</u>	
	Saturday.			deficient practice will not		
	The Martha Charles	during traction D 1 (MAD) C		recur, i.e., what quality		
		dministration Record (MAR) for		assurance programs will be pu	t	
		023, 10/2023 and 11/2023		into place;		
		redilol was administered on $9/16$,		Nurse managers will randomly		
		/26, 9/28, 10/3, 10/5, 10/10, 10/12,		audit 5 residents Medication		
		1, 10/26, 10/28, 10/31, 11/2 and		Administration Record (MAR)		
	11/4/23, all of whi	ich were dialysis days.		weekly to ensure medications ar	e	
				being administered/held per		
	The Physician's O	rder for the Carvedilol was	1	physician parameters.		

	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155131	(X2) MULTIPLE C A. BUILDING B. WING	onstruction 00	СОМ	e survey pleted 10/2023
	PROVIDER OR SUPPLIE	R	7935 C	ADDRESS, CITY, STATE, ZIP C CALUMET AVE TER, IN 46321	OD	
(X4) ID PREFIX TAG	SUMMARY (EACH DEFICIE REGULATORY C changed on 11/7/2 6.25 mg one time a than 60 and/or sys 100.	Y STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION 3. The new order was Carvedilol a day. Hold for heart rate less tolic blood pressure less than	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE A DEFICIENCY) The Director of Nursing will present a summary audits to the Quality As committee monthly for Thereafter, if determine	AULD BE APPROPRIATE g/designee y of the ssurance 4 months. ed by the	(X5) COMPLETION DATE
	be administered at rate or blood press administration of t Interview with the 11/20/23 at 9:00 a medications should days as ordered an	Second Floor Unit Manager on m., indicated the blood pressure d have been held on dialysis d the resident's blood pressure e checked prior to the		Quality Assurance com auditing and monitoring done quarterly and pre quarterly at the QA me Monitoring will be on g Date by which system corrections will be co 12/4/2023	g will be sent eting. oing. iic	
⁻ 0758 SS=D Bidg. 00	483.45(c)(3)(e)(1 Free from Unnec Use §483.45(e) Psycl §483.45(c)(3) A p drug that affects with mental proce drugs include, bu the following cate (i) Anti-psychotic (ii) Anti-depressa (iii) Anti-anxiety; (iv) Hypnotic Based on a comp resident, the faci §483.45(e)(1) Re	Psychotropic Meds/PRN notropic Drugs. osychotropic drug is any brain activities associated esses and behavior. These at are not limited to, drugs in egories: ; ; int; and orehensive assessment of a lity must ensure that				
	unless the medic	gs are not given these drugs ation is necessary to treat a as diagnosed and				

	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE C A. BUILDING	construction (x	(3) DATE SURVEY COMPLETED	
		155131	B. WING		11/20/2023	
NAME OF	PROVIDER OR SUPPLIE	R		ADDRESS, CITY, STATE, ZIP COD		
MUNST	ER MED-INN			STER, IN 46321		
(X4) ID PREFIX		STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	(X5) COMPLETION	
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION e clinical record;	TAG	DEFICIENCY)	DATE	
	reductions, and b unless clinically of to discontinue the §483.45(e)(3) Re psychotropic drug unless that media a diagnosed spee documented in th §483.45(e)(4) PF drugs are limited provided in §483 physician or press that it is appropri- extended beyond document their ra medical record a the PRN order. §483.45(e)(5) PF drugs are limited renewed unless the prescribing pract for the appropriate Based on record re failed to ensure the of a psychotropic to	gs receive gradual dose ehavioral interventions, ontraindicated, in an effort	F 0758	Munster Med-Inn Annual Survey: 11/20/2023 Please accept the following as the facility's credible allegation of	12/04/202 he	
	Finding includes:	ident 23 was reviewed on		compliance. This plan of correction does not constitute ar admission of guilt or liability by t facility and is submitted only in		
	11/16/23 at 11:00	a.m. Diagnoses included, but , high blood pressure, anemia,		response to the regulatory requirement.		

I 155131 B. WING 11/20/2023 NAME OF PROVIDER OR SUPPLIER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP COD 7935 CALUMET AVE MUNSTER, IN 46321 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE PREFIX (X4) ID SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL ID PROVIDERS PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE COM		NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	. ,	E CONSTRUCTION	· /	E SURVEY
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antipsychotic medication related to a behavior disturbance diagnosis and the resident had not been seen by any other behavioral services.recur, i.e., what quality assurance programs will be put into place; Social Services Director/Designee		at 12:40 p.m., indi	cated the resident was on an				1
disturbance diagnosis and the resident had not assurance programs will be put been seen by any other behavioral services. into place; Social Services Director/Designee		-			-		1
been seen by any other behavioral services. into place; Social Services Director/Designee		disturbance diagno	osis and the resident had not				1
Social Services Director/Designee						-	1
					-	tor/Designee	1
		3.1-48(a)(4)				-	
receiving psychotropic					-		1
medications weekly to ensure							1

	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155131	(X2) MULT A. BUILE B. WING		NSTRUCTION 00	(X3) DATE COMPI 11/20	
	PROVIDER OR SUPPLIE ER MED-INN	R	7	935 CA	DDRESS, CITY, STATE, ZIP COD ALUMET AVE ER, IN 46321	•	
(X4) ID PREFIX TAG	(EACH DEFICIE)	STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	PRI	D EFIX AG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRO DEFICIENCY) there is an appropriate diagnosis/indication for use The Director of Nursing/de	DBE PRIATE	(X5) COMPLETION DATE
					will present a summary of audits to the Quality Assur committee monthly for 4 m Thereafter, if determined b Quality Assurance commit auditing and monitoring wil done quarterly and presen quarterly at the QA meetin Monitoring will be on going Date by which systemic corrections will be compl 12/4/2023	the ance onths. y the tee, II be t g.	
⁼ 0812 SS=F Bldg. 00	§483.60(i) Food s The facility must §483.60(i)(1) - Pr approved or cons federal, state or I (i) This may inclu directly from loca applicable State a regulations. (ii) This provision facilities from usin gardens, subject applicable safe g practices. (iii) This provision	ocure food from sources idered satisfactory by ocal authorities. de food items obtained I producers, subject to					

STATEME	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MU	LTIPLE CO	ONSTRUCTION (2	X3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUI	LDING	00	COMPLETED
		155131	B. WIN	IG		11/20/2023
NAME OF	PROVIDER OR SUPPLIE	ĒR			ADDRESS, CITY, STATE, ZIP COD	
MUNST	ER MED-INN				ALUMET AVE FER, IN 46321	
MONOT				MONOI		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	(EACH DEFICIE	NCY MUST BE PRECEDED BY FULL	Р	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	COMPLETI
TAG	REGULATORY C	OR LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	DATE
		tore, prepare, distribute and				
	serve food in acc	cordance with professional				
	standards for foo	d service safety.				
	Based on observat	ion, record review, and	F 08	12	Munster Med INN	12/04/20
		lity failed to serve food under			Annual Survey: 11/20/2023	
	sanitary conditions	s related to beverages being			Please accept the following as t	the
	uncovered while b	eing transported down the			facility's credible allegation of	
	hallway for 1 of 1	meal observations. The facility			compliance. This plan of	
	also failed to store	and prepare food under			correction does not constitute a	n
	sanitary conditions	s related to dried spillage on the			admission of guilt or liability by t	the
	floor, walls, and d	oor, and a build up of grease			facility and is submitted only in	
	and grime on the f	ood preparation equipment for 1			response to the regulatory	
	of 1 kitchens. (Th	e Fourth Floor and the Main			requirement.	
	Kitchen)				F812 Food Procurement,	
					Store/Prepare/Serve/Sanitary	
	Findings include:				What corrective action(s) will	
	C C				be accomplished for those	
	1. On 11/17/23 at	11:32 a.m., the beverage cart was			residents found to have been	
		ourth floor. At 11:50 a.m., a staff			affected by the deficient	
	member was obser	rved placing 10 styrofoam cups			practice;	
	on the ledge of the	nurses' station and filling them			Beverages being transported do	own
	with juice.	-			the hall were immediately cover	
	-				appropriately.	
	At 11:52 a.m., stat	ff members were observed			Liquid spills were cleaned from	
	placing the uncove	ered cups on residents' lunch			floors, doors, and walls. Grease	
	trays and walking	down the hall.			and grim was cleaned from the	
					food preparation equipment	
	Interview with the	Assistant Director of Nursing			including the stove top and fire	
		/23 at 3:18 p.m., indicated the			irons.	
	cups should have l				The cup of undated food in the	
					cooler was immediately discard	ed.
	The facility policy	titled "In-Room Dining" was			The convection oven was clean	
		DON on 11/20/23 at 3:18 p.m.			of dried food and grease built u	
		urrent. The policy indicated all			on top and inside.	1
		overed during transport. 2.			How the facility will identify	
		kitchen tour on $11/14/23$ at 8:47			other residents having the	
		l Service Director, the following			potential to be affected by the	
	was observed:	····, ···· ······			same deficient practice and	
					what corrective action will be	
	a. The stove top at	nd fire irons had a build up of			taken;	
			1		unon,	1

	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155131	(X2) MULTIPLE C A. BUILDING B. WING	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 11/20/2023	
	PROVIDER OR SUPPLIE	BR	7935 0	ADDRESS, CITY, STATE, ZIP COD CALUMET AVE TER IN 46321		
MUNST (X4) ID PREFIX TAG	 (EACH DEFICIE REGULATORY C grease and debris. b. There were cup dates. c. There was brow the entry door, on appliances. d. The convection build up of grease grease build up on Interview with the 11/14/23 at 9:00 a 	Food Service Director on .m., indicated she was working dule, job assignments and		TER, IN 46321 PROVIDER'S PLAN OF CORRECTIVE CROSS-REFERENCED TO THE APPROP DEFICIENCY) All residents have the poter be affected by the alleged of practice. What measures will be put place or what systemic changes will be made to ensure that the deficient practice does not recur; Dietary managers/dietary st were re-educated on: Keeping clean of debr such as liquid spills, splashe grease and grim build up. Keeping convection oven/oven clean Properly labeling/datir in cooler Staff were educated on: Covering food and ber before transporting How the corrective action(will be monitored to ensur deficient practice will not recur, i.e., what quality assurance programs will b into place; Administrator/Designee will kitchen 2 times per week to ensure cleanliness/sanitation the kitchen areas is maintation Facility Angel's will audit met tray pass 3 times per week to ensure food/beverages are prior to transferring to reside rooms. Administrator/designee will present a summary of the a to the Quality Assurance	The put audit of and the put audit of an of ned. eal to covered ent	(X5) COMPLETIO DATE

	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	A. BU	JILDING	onstruction 00	COM	TE SURVEY
		155131	B. W.	ING		11/2	20/2023
NAME OF I	PROVIDER OR SUPPLIE	R			ADDRESS, CITY, STATE, ZIP CO)	
MUNSTE	ER MED-INN				CALUMET AVE TER, IN 46321		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID			(X5)
PREFIX		NCY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP	CTION ULD BE	COMPLETION
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	ROPRIATE	DATE
					Quality Assurance comm auditing and monitoring done quarterly and prese quarterly at the QA meet Date by which systemi corrections will be com 12/4/2023	will be ent ting. c	
F 0921 SS=E Bldg. 00	§483.90(i) Other The facility must sanitary, and con residents, staff an Based on observati failed to ensure the clean and in good in marred walls, loos missing tiles, and p contained for 4 of (The Second, Third Findings include: During the Environ Maintenance and P 11/20/23 at 9:38 a. 1. Second Floor a. On 11/14/23 at observed. The floo accumulation of fc between the beds, cracked, and the co were dirty. The re hospital leave.	ion and interview, the facility e residents' environment was repair related to dirty floors, e baseboards, lime build up, bersonal care items not 5 floors throughout the facility. d, and Fourth floors) nmental tour with the Housekeeping Supervisors on m., the following was observed: 10:52 a.m., Room 205 was or mats were dirty, there was an od debris on the floor in the raised toilet seat was orners of the bathroom floor sident was currently out on	F 09	921	Munster Med INN Annual Survey: 11/20/2 Please accept the follow facility's credible allegati compliance. This plan o correction does not cons admission of guilt or liab facility and is submitted response to the regulato requirement. F921 Safe/Functional/Sanitar ortable Environment What corrective action() be accomplished for th residents found to have affected by the deficient practice; Housekeeping was notific cleaning needs for room 213, 215, 220, 223, 325, including dirty floors, fau up, dirty floor mats, soile nightstand, and soiled be commode. Maintenance was notifie	ing as the on of f stitute an ility by the only in ry y/Comf s) will ose been t ed of s: 205, and 329 cet build d edside	12/04/202

DEPARTMENT OF HEALTH AND HUMAN SERVICES

	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155131	(X2) MULTIPLE C A. BUILDING B. WING	00	(X3) DATE SURVEY COMPLETED 11/20/2023
	provider or supplie ER MED-INN	R	7935 0	ADDRESS, CITY, STATE, ZIP COD CALUMET AVE ITER, IN 46321	
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	(EACH DEFICIE	NCY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	COMPLET
TAG	REGULATORY C	R LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)	DATE
	missing ceramic w	all tile next to the toilet, and the		for repairs needed in rooms: 2	205,
	walls were marred	in the room. One resident		213, 325, 407, and 408 includ	ing
	resided in the roor	n and 3 residents shared the		cracked toilet seat, scratched	
	bathroom.			walls, marred walls, and peeli	ng
				baseboards.	
	c. In the bathroon	n of Room 215, there was a		Resident personal items were	
	toothbrush face do	wn on the ledge below the		stored/appropriately contained	l.
	mirror and there w	as a urinal on the top ledge		How the facility will identify	
	below the mirror.	There was also a pool of water		other residents having the	
	underneath the toi	let. Two residents shared the		potential to be affected by th	e
	bathroom.			same deficient practice and	
				what corrective action will be	e
		n Room 220 had an accumulation		taken;	
	of dust and dirt an	d was in need of cleaning. Two		All facility residents have the	
	residents resided in	n this room.		potential to be affected by the	
				same alleged deficient practic	e.
		and debris on the floor of Room		What measures will be put in	nto
		ight stand also had an		place or what systemic	
		ried spillage. One resident		changes will be made to	
	resided in this root	m.		ensure that the deficient	
				practice does not recur;	
	2. Third Floor			Staff were educated on:	
				Notifying	
		Room 325 was dusty and dirty.		maintenance/environmental	
	The wall by bed 1	was scratched and marred.		services of any necessary rep	airs
				or cleaning needed.	
		mmode in Room 329 for bed 2		Keeping residents' perso	
	had bowel movem	ent in the container.		items contained/stored proper	-
				How the corrective action(s)	
	3. Fourth Floor			will be monitored to ensure t	ine
	- The 111 1	4 h - 4 2 in D 407		deficient practice will not	
		d bed 2 in Room 407 was		recur, i.e., what quality	
		red. Two residents resided in		assurance programs will be	put
	the room.			into place;	
	1. The 111 1	1 h - 1 1 in D 400		The Maintenance Director will	
		d bed 1 in Room 408 was		audit 5 rooms per week on	
		red and the baseboard was		alternating units for maintenar	ice
		the wall. One resident resided		issues. Any issues will be	
	in this room.			corrected.	
				Facility Angel's will audit 10	

PRINTED: 12/20/2023 FORM APPROVED

EPARTMENT OF HEALTH AND HUMAN SERVICES ENTERS FOR MEDICARE & MEDICAID SERVICES							FORM APPROVED OMB NO. 0938-039	
STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155131		IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION A. BUILDING D B. WING			(X3) DATE SURVEY COMPLETED 11/20/2023		
	ROVIDER OR SUPPLIEF R MED-INN	2		7935 C	ADDRESS, CITY, STATE, ZIP COD ALUMET AVE FER, IN 46321			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION		р	ID PROVIDER'S PLAN OF CORRECTIO PREFIX (EACH CORRECTIVE ACTION SHOULD) CROSS-REFERENCED TO THE APPROF TAG DEFICIENCY)		ATE	(X5) COMPLETION DATE	
	the above were in n	Maintenance and f at that time, indicated all of eed of cleaning and/or repair. to Complaint IN00420643.			resident rooms 3 times per we to ensure personal items are contained/stored properly. The Administrator/designee w present a summary of the aud to the Quality Assurance committee monthly for 4 mont Thereafter, if determined by th 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 complete 12/4/2023	vill lits ths. he e		

1 Facility ID: 000056

0056 If continua

If continuation sheet Page 49 of 49