

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155131	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  10/09/2014
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NAME OF PROVIDER OR SUPPLIER  MUNSTER MED-INN	STREET ADDRESS, CITY, STATE, ZIP CODE 7935 CALUMET AVE MUNSTER, IN 46321
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F000000	<p>This visit was for the Investigation of Complaint IN00156853.</p> <p>This visit was in conjunction to the Post Survey Revisit (PSR) to Complaint IN00155605 completed on 9/8/14.</p> <p>Complaint IN00156853- Substantiated. Federal/ State deficiency related to the allegation is cited at F309.</p> <p>Survey date: October 9, 2014</p> <p>Facility number: 000056 Provider number: 155131 AIM number: 100289450</p> <p>Survey team: Cynthia Stramel, RN, TC Yolanda Love, RN</p> <p>Census bed type: SNF: 20 SNF/NF: 178 Total: 198</p> <p>Census payer type: Medicare: 44 Medicaid: 120 Other: 34 Total: 198</p>	F000000		
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE \_\_\_\_\_ TITLE \_\_\_\_\_ (X6) DATE \_\_\_\_\_

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F000309 SS=D	<p>Sample: 7</p> <p>These deficiencies reflect state findings in accordance with 410 IAC 16.2-3.1.</p> <p>Quality review completed on October 12, 2014, by Janelyn Kulik, RN.</p> <p>483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. Based on observation, record review and interview, the facility failed to provide necessary care and services related to assessment and monitoring of a skin tear until healed for 1 of 3 residents reviewed for non pressure skin issues. (Resident #D)</p>	F000309	<p>The facility respectfully requests the department to consider paper compliance for citation F309.</p> <p>Please accept the following as the facility's credible allegation of compliance. This plan of correction does not constitute an</p>	10/24/2014
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	<p>Findings include:</p> <p>On 10/9/14 at 8:00 a.m., Resident #D was observed with CNA #1. The resident had a noticeable scabbed area on the back of her left leg approximately 2.0 centimeters (cm) x .5 cm.</p> <p>The resident's record was reviewed on 10/9/14 at 8:30 a.m. The resident's diagnoses included, but were not limited to, dementia with behaviors and atrial fibrillation. She received Coumadin (a blood thinner) daily.</p> <p>The quarterly Minimum Data Set assessment dated 9/27/14 indicated the resident was rarely or never understood. She required extensive, two person assistance for transfers and bed mobility.</p> <p>Nursing note dated 9/20/14 indicated the resident had a skin tear noted on her left leg. The initial skin assessment indicated the skin tear was 2.0 cm x .4 cm. The Physician was notified, and an order dated 9/20/14 was received to apply Steri-strips and monitor the site daily for signs of infection.</p> <p>Nursing note dated 9/22/14 indicated the Steri strips had fallen off and the wound showed no sign of infection.</p>		<p>admission of guilt or liability by the facility and is submitted only in response to the regulatory requirement.</p> <p>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; RD's left lower leg was assessed. The physician and family was made aware of the scab to the left lower leg.</p> <p>How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken; All facility residents who have skin tears/scabs have the potential to be affected by the same deficient practice. The nurse and unit managers were in-service and assessment and documentation of a healed scab. An audit was completed for residents who have skin tears and scabs. All had the appropriate monitoring system in place.</p> <p>What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur; The DON/designee in-service licensed nurses on:</p> <ol style="list-style-type: none"> <li>1. Assessment and documentation of skin tears/scabs, including on-going monitoring until healed.</li> <li>2. Documentation of healed skin tears/scabs.</li> </ol> <p>How the corrective action(s) will</p>				

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	<p>Nursing note dated 9/30/14 indicated the wound had healed. There were no further assessments in the Nursing notes related to the skin tear.</p> <p>A Weekly Skin Assessment dated 10/6/14, had check marked "yes" next to skin tears. There was no additional information related to the location or assessment of a skin tear.</p> <p>Interview with the Unit Manager and Nurse Consultant on 10/9/14 at 12:15 p.m., indicated skin tears should be measured once when initially noted, then monitored daily until healed. The Unit Manager and Nurse Consultant indicated the Nursing notes had indicated the wound was healed on 9/30/14. They observed the resident's left leg at that time and indicated there was a skin tear still present.</p> <p>This Federal tag relates to Complaint IN00156853.</p> <p>3.1-37(a)</p>		<p>be monitored to ensure the deficient practice will not recur, i.e., what quality assurance programs will be put into place; The DON/ designee will audit five residents who have skin tears or scabs weekly to ensure that documentation of the skin tear/scab is completed accurately. Any compliance concerns will be addressed with the appropriate nurse or unit manager. The DON/designee will present a summary of the audits to the Quality Assurance committee monthly for nine months. Thereafter, as determined by the Quality Assurance committee, auditing and monitoring will be done quarterly and presented quarterly at the QA meeting for review and recommendations.</p>		