STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155131	A. BUILDING 00 B. WING	11/09/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 0000 Bldg. 00	This visit was for a Recertification and State Licensure Survey. This visit included the Investigation of Complaints IN00392363 and IN00393937. Complaint IN00392363 - Substantiated. No deficiencies related to the allegations are cited. Complaint IN00393937 - Substantiated. No deficiencies related to the allegations are cited. Survey dates: October 31, November 1, 2, 3, 4, 7, and 9, 2022 Facility number: 000056 Provider number: 155131 AIM number: 100289450 Census Bed Type: SNF: 14 SNF/NF: 160 Total: 174 Census Payor Type: Medicare: 40 Medicaid: 111 Other: 23 Total: 174 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on 11/14/22.	F 0000	The facility respectfully asks for a desk review.	
F 0554 SS=D Bldg. 00	483.10(c)(7) Resident Self-Admin Meds-Clinically Approp §483.10(c)(7) The right to self-administer			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Robert A Petty
TITLE: Administrator
(X6) DATE: 11/23/2022

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

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	medications if the interdisciplinary team, as defined by §483.21(b)(2)(ii), has determined that this practice is clinically appropriate. Based on observation, record review, and interview, the facility failed to ensure residents had Physician's Orders for medications and an assessment to self-administer their own medications for 2 of 2 residents reviewed for self-administration of medication. (Residents 148 and 173) Findings include: 1. During a random observation on 10/31/22 at 10:54 a.m., Resident 148 was observed to have a tube of hydrocortisone cream (an anti-itch cream) on her over bed table. She also had a box containing another tube of hydrocortisone cream and a bottle of Omega XL tablets (a dietary supplement) which was in the plastic bin located on top of another over bed table. Interview with the resident at that time, indicated the top of her left hand itched and she had some redness. She had been applying the hydrocortisone cream and she ordered the Omega XL tablets which had seemed to help. On 11/1/22 at 9:31 a.m., the box of hydrocortisone cream and the bottle of Omega XL tablets remained in the plastic bin on the over bed table. On 11/2/22 at 10:14 a.m., 11:43 a.m., and 1:41 p.m., the hydrocortisone cream and Omega XL tablets remained in the resident's room. The record for Resident 148 was reviewed on 11/2/22 at 1:11 p.m. Diagnoses included, but were not limited to, type 2 diabetes mellitus and dermatitis (skin inflammation).	F 0554	**Munster Med-Inn** **Annual Survey: 11/9/2022** Please accept the following as the facility's credible allegation of compliance. This plan of correction does not constitute an admission of guilt or liability by the facility and is submitted only in response to the regulatory requirement. **F554 Resident Self Admin Meds-Clinically Appropriate** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;** A self-administration assessment was completed for Resident 148. Resident 148's physician was notified and Omega XL and Hydrocortisone use were discontinued. Medications were removed from the bedside at this time. Resident was educated to inform the nurse before ordering or taking any additional medication not provided by the facility. A self- administration assessment was competed for Resident 173. Resident 173's Physician was notified, and orders were received for resident to self-administer Trelegy Ellipta inhaler and Proventil HFA inhaler. Orders were also received to allow resident to	11/21/2022

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	The Annual Minimum Data Set (MDS) assessment, dated 9/7/22, indicated the resident was cognitively intact. The October 2022 Physician's Order Summary (POS), indicated the resident did not have an order for the hydrocortisone cream and the Omega XL tablets. A Self-Administration of Medication assessment had not been completed for the resident. Interview with the Director of Nursing (DON) on 11/3/22 at 10:40 a.m., indicated the resident had a history of ordering items online and she didn't tell staff. The DON also indicated the resident would be assessed for self-administering medications and she would be educated to notify staff when she ordered any medications or treatments. 2. During random observations on 10/31/22 at 2:01 p.m., 11/1/22 at 10:00 a.m., and 11/2/22 at 11:05 a.m., and 3:04 p.m., Resident 173 was observed in bed. At those times, there were 3 handheld respiratory inhalers noted on the resident's over bed table and dresser. There were 2 Proventil HFA Albuterol Sulfate inhalers and 1 Trelegy Ellipta inhaler. The record for Resident 173 was reviewed on 11/1/22 at 4:12 p.m. Diagnoses included, but were not limited to, chronic obstructive pulmonary disease (COPD), type 2 diabetes, and weakness. The 10/11/22 Admission Minimum Data Set (MDS) assessment, indicated the resident was cognitively intact. There was no Care Plan which indicated the resident could self-administer her own		keep inhalers at the bedside. **How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken;** All facility residents with medication orders have the potential to be affected by the same alleged deficient practice. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur;** Staff were educated on not leaving medications at resident bedside unless there is an order for self-administration in place. Staff were also educated on ensuring medications are stored properly. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance programs will be put into place;** Facility Angel's will audit 15 residents 3 days per week to ensure no medication is improperly stored at the bedside. The Director of Nursing/designee will present a summary of the audits to the Quality Assurance committee monthly for 6 months. Thereafter, if determined by the Quality Assurance committee, auditing and monitoring will be	

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	medications. There was no Self-Administration of Medication assessment. Physician's Orders, dated 10/5/22, indicated the resident was to receive Proventil HFA Albuterol Sulfate inhaler, inhale 2 puffs every 4 hours as needed (prn) and Trelegy Ellipta inhaler 100-62.5-25 micrograms, inhale 1 puff daily. Interview with the Director of Nursing on 11/3/22 at 10:30 a.m., indicated the inhalers should not have been left in the resident's room. 3.1-11(a)		done quarterly and present quarterly at the QA meeting. Monitoring will be on going. **Date by which systemic corrections will be completed: 11/21/2022**	
F 0558 SS=D Bldg. 00	483.10(e)(3) Reasonable Accommodations Needs/Preferences §483.10(e)(3) The right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences except when to do so would endanger the health or safety of the resident or other residents. Based on observation, record review, and interview, the facility failed to accommodate the needs of a dependent resident related to the call light being out of reach for 1 of 34 residents observed for call light positioning. (Resident 65) Finding includes: On 10/31/22 at 11:20 a.m., Resident 65 was observed awake in her bed visiting with her family. The call light was noted to be wrapped around the right upper bed rail. The call light was out of the resident's reach.	F 0558	**Munster Med-Inn** **Annual Survey: 11/09/2022** Please accept the following as the facility's credible allegation of compliance. This plan of correction does not constitute an admission of guilt or liability by the facility and is submitted only in response to the regulatory requirement. **F558 Reasonable accommodations of Needs/Preferences**	11/21/2022

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	Interview with the resident on 10/31/22 at 11:20 a.m., indicated she didn't know where her call light was, but she was able to use it if it were placed under her left hand. On 11/1/22 at 9:08 a.m., the resident was awake in her bed watching television. The call light was still hanging from the right upper bed rail and out of reach. On 11/2/22 at 9:06 a.m., the resident's call light was wrapped around the right upper bed rail and out of reach. The record for Resident 65 was reviewed on 11/2/22 at 2:45 p.m. Diagnoses included, but were not limited to, Multiple Sclerosis and dysphagia (difficulty swallowing). The Quarterly Minimum Data Set (MDS) assessment, dated 8/24/22, indicated the resident was cognitively intact and was dependent on staff for personal hygiene, eating, and mobility. A Care Plan for Activities of Daily Living (ADL's) and functional status, last reviewed and revised on 9/7/22, indicated the resident's call light should be kept within reach. A Care Plan related to falls and safety, last reviewed and revised on 9/7/22, indicated the call light should be kept within the resident's reach at all times while in her room. Interview with the 200 Unit Manager on 11/2/22 at 9:10 a.m., indicated the call light should have been in reach for the resident. 3.1-3(v)(1)		**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;** Resident 65's- call light was immediately placed within resident reach. **How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken;** All residents have the potential to be affected by the same alleged deficient practice. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur;** Staff were re-educated on ensuring resident call lights are positioned within reach while in their room. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance programs will be put into place;** Facility angels will complete round observations for 15 residents 3 times per week to ensure call light is within resident reach. Administrator/designee will present a summary of the audits to the Quality Assurance committee monthly for 6 months. Thereafter, if determined by the	

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			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: 11/21/2022**	
F 0583 SS=D Bldg. 00	483.10(h)(1)-(3)(i)(ii) Personal Privacy/Confidentiality of Records §483.10(h) Privacy and Confidentiality. The resident has a right to personal privacy and confidentiality of his or her personal and medical records. §483.10(h)(l) Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident. §483.10(h)(2) The facility must respect the residents right to personal privacy, including the right to privacy in his or her oral (that is, spoken), written, and electronic communications, including the right to send and promptly receive unopened mail and other letters, packages and other materials delivered to the facility for the resident, including those delivered through a means other than a postal service. §483.10(h)(3) The resident has a right to secure and confidential personal and medical records. (i) The resident has the right to refuse the			

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	release of personal and medical records except as provided at §483.70(i)(2) or other applicable federal or state laws. (ii) The facility must allow representatives of the Office of the State Long-Term Care Ombudsman to examine a resident's medical, social, and administrative records in accordance with State law.			
	Based on observation, record review, and interview, the facility failed to ensure residents had their personal privacy respected related to the posting of medical and personal information for 2 of 2 residents reviewed for privacy. (Residents 72 and 102) Findings include: 1. During a random observation on 10/31/22 at 11:15 a.m., Resident 72 was in her room in bed. Two signs were posted above her bed, one indicating she was NPO (nothing by mouth) and the other indicated essential water provided by the family was to be used for her tube feeding flush. Random observations on 11/1 at 9:43 a.m., 11/2 at 10:08 a.m. and 1:35 p.m., and 11/3/22 at 11:40 a.m., indicated the sign remained above the resident's bed related to using the essential water for her tube feeding flushes. The record for Resident 72 was reviewed on 11/2/22 at 10:21 a.m. Diagnoses included, but were not limited to, stroke and dysphagia (difficulty swallowing). The Quarterly Minimum Data Set (MDS) assessment, dated 9/1/22, indicated the resident was cognitively impaired for daily decision making.	F 0583	Munster Med-Inn Annual Survey: 11/09/2022 Please accept the following as the facility's credible allegation of compliance. This plan of correction does not constitute an admission of guilt or liability by the facility and is submitted only in response to the regulatory requirement. **F583 Personal Privacy/Confidentiality of Records** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;** Resident 72- NPO sign, and essential water sign were removed from above the resident's bed. The residents plan of care has been updated accordingly. Resident 120 – Personal Items note, and vitals signs were immediately removed. The fluid restriction sign was moved to the inside of the bathroom door with a cover sheet placed on top. **How the facility will identify other residents having the**	11/21/2022

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	There was no current Care Plan related to personal care signs being posted in the resident's room. Interview with the Director of Nursing on 11/3/22 at 10:40 a.m., indicated the family put up the signs and a Care Plan should have been completed. 2. During a random observation on 11/1/22 at 9:45 a.m., Resident 102 was observed lying in bed. At that time, there was a sign above her bed that stated, "Please put all of my items on the right side so I can see." Another sign for the resident's fluid restriction was posted on the outside of the bathroom door, which was in view for visitors to see. There was also a vital sign flow sheet on the outside of her door for everyone to view who walked past the door. All of the signs had personal information regarding the resident. The record for Resident 102 was reviewed on 11/2/22 at 11:47 a.m. The resident was admitted to the facility on 9/20/22. Diagnoses included, but were not limited to, stroke, end stage renal disease and dependence on renal dialysis. The Admission Minimum Data Set (MDS) assessment, dated 9/26/22, indicated the resident was not cognitively intact and received dialysis as a resident. A Care Plan, dated 9/20/22, indicated the resident had impaired vision. There was no Care Plan indicating the resident wished for her medical information to be displayed on the outside of the bathroom door, on the outside of the room door, or above the bed. Interview with the Director of Nursing on 11/3/22 at 10:30 a.m., indicated the fluid restriction sign		**potential to be affected by the same deficient practice and what corrective action will be taken;** All residents have the potential to be affected by the same alleged deficient practice. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur;** Staff were educated to ensuring residents personal information/records are kept confidential. Staff were educated to ensure all signs that are posted in residents' rooms have a cover sheet over them. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance programs will be put into place;** Facility angels will complete round observations for 15 residents 3 times per week to ensure any persona care signs in resident care areas are covered appropriately. Administrator/designee will present a summary of the audits to the Quality Assurance committee monthly for 6 months. Thereafter, if determined by the Quality Assurance committee, auditing and monitoring will be done quarterly and present	

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	should have been on the inside of the bathroom door. There should be no signs above the resident's bed. The vital sign flow sheets had been removed from the resident room doors. 3.1-3(p)(4)		quarterly at the QA meeting. Monitoring will be on going. Date by which systemic corrections will be completed: 11/21/2022	
F 0656 SS=D Bldg. 00	483.21(b)(1)(3) Develop/Implement Comprehensive Care Plan §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)-			

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	(A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. §483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (iii) Be culturally-competent and trauma-informed.			
	Based on record review and interview, the facility failed to develop and implement a Care Plan for a diuretic medication for 1 of 37 residents reviewed for care plans. (Resident 110) Finding includes: Resident 110's record was reviewed on 11/2/22 at 10:51 a.m. Diagnosis included, but were not limited to, dementia with behavioral disturbance, anxiety disorder, and congestive heart failure. The Quarterly Minimum Data Set (MDS) assessment, dated 10/15/22, indicated the resident was cognitively impaired and had received a diuretic medication. The Physician's Order Summary, dated 11/2022, indicated an order for furosemide (Lasix, a diuretic medication) 20 mg (milligrams) three times a day. The Medication Administration Record, dated 10/2022, indicated the resident had received the	F 0656	**Munster Med-Inn** **Annual Survey: 11/9/2022** Please accept the following as the facility's credible allegation of compliance. This plan of correction does not constitute an admission of guilt or liability by the facility and is submitted only in response to the regulatory requirement. **F656 Development/Implement Comprehensive Care Plan** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;** A care plan was initiated for diuretic therapy for resident 110. **How the facility will identify other residents having the potential to be affected by the same deficient practice and**	11/21/2022

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	diuretic medication as ordered. There was a lack of a Care Plan pertaining to the diuretic medication use. Interview with the Director of Nursing (DON) on 11/3/22 at 10:33 a.m., indicated she would review the resident's care plans. 3.1-35(a)		**what corrective action will be taken;** All residents with orders for diuretic therapy have the potential to be affected by this alleged deficient practice. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur;** Staff were educated on ensuring care plans are initiated/updated for residents with new orders and/or change in condition. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance programs will be put into place;** Nurse managers will audit 10 residents with new medication orders weekly to ensure care plans are initiated/updated. The Director of Nursing/designee will present a summary of the audits to the Quality Assurance committee monthly for 6 months. Thereafter, if determined by the Quality Assurance committee, auditing and monitoring will be done quarterly and present quarterly at the QA meeting. Monitoring will be on going. **Date by which systemic corrections will be completed: 11/21/22**	

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F 0657 SS=D Bldg. 00	483.21(b)(2)(i)-(iii) Care Plan Timing and Revision §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments.			
	Based on record review and interview, the facility failed to ensure the residents were involved in making decisions about their care related to informing them of new medications and treatments for 1 of 2 residents reviewed for participation in care planning. (Resident 173) Finding includes:	F 0657	**Munster Med-Inn** **ANNUAL SURVEY: 11/9/2022** Please accept the following as the facility's credible allegation of compliance. This plan of correction does not constitute an admission of guilt or liability by the facility and is submitted only in	11/21/2022

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	During an interview with Resident 173 on 10/31/22 at 2:01 p.m., she indicated the staff would inform her daughter more than they would tell her what was going on. The resident indicated she was capable of making her own decisions. The record for Resident 173 was reviewed on 11/1/22 at 4:12 p.m. Diagnoses included, but were not limited to, chronic obstructive pulmonary disease (COPD), type 2 diabetes, depressive disorder, protein calorie malnutrition, and weakness. The 10/11/22 Admission Minimum Data Set (MDS) assessment, indicated the resident was cognitively intact. The resident had no oral problems and weighed 124 pounds with no significant weight loss noted. A Registered Dietitian's Progress Note, dated 10/10/22 at 8:26 a.m., indicated the resident was admitted from another facility. The resident weighed 124 pounds on 10/5/22. Diagnosis of diabetes, recommend clarify diet order to no concentrated sweets and no added salt, regular texture diet with thin liquids. Due to varied intakes, also recommend to add a house supplement of 120 milliliters (mls) twice a day for additional support. A Nurses' Note, dated 10/10/22 at 3:21 p.m., indicated the resident's Responsible Party was notified of the update of care. A Nurses' Note, dated 10/12/22 at 9:16 a.m., indicated a new order from the doctor was received for the resident to be treated and evaluated by psychiatric services. The Responsible Party was made aware.		response to the regulatory requirement. **F657 Care Plan Timing and Revision** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:** Resident R173 was immediately updated current plan of care. **How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken;** All residents with a change in condition have the potential to be affected by the same alleged deficient practice. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:** Staff were educated on notifying the resident and to include the resident in decision making related to the plan of care, responsible party, and physician when there is a change in condition and/or plan of care. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance programs will be put into place;** Nurse Managers will audit 10	

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	A Nurse Practitioner Progress Note, dated 10/14/22 at 4:16 p.m., indicated the resident was seen at the bedside. She reported not feeling well and coughing up yellow sputum. The staff indicated the resident was refusing the Lidocaine patch (a patch for pain). A new prescription for Lorazepam (an anti-anxiety medication) 0.5 milligrams (mg) tablet, take 1 tablet by mouth twice a day was received. The resident had a productive cough with complaints of coughing up yellow phlegm, a chest x-ray was ordered. Nurses' Notes, dated 10/14/22 at 2:42 p.m., indicated new orders were received to increase the resident's Ativan (Lorazepam) to twice a day and a chest x-ray was ordered. The resident's daughter was made aware of the new orders . Nurses' Notes, dated 10/14/22 at 5:59 p.m., indicated the chest x-ray was ordered through the facility's contracted source. The resident's Responsible Party was notified. Nurses' Notes, dated 10/15/22 at 12:33 p.m., indicated the Physician was made aware of the chest x-ray results. No new orders were received. Interview with the Director of Nursing on 11/3/22 at 2:00 p.m., indicated the resident was to be informed of all new medications, treatments, or services. 3.1-35(d)(2)(B)		residents with change in conditions weekly to ensure resident and notified and included in the decision making, responsible party, and physicians are notified timely of change in resident condition. The Director of Nursing/designee will present a summary of the audits to the Quality Assurance committee monthly for 6 months. Thereafter, if determined by the Quality Assurance committee, auditing and monitoring will be done quarterly and present quarterly at the QA meeting. Monitoring will be on going. **Date by which systemic corrections will be completed: 11/21/2022**	
F 0677 SS=D Bldg. 00	483.24(a)(2) ADL Care Provided for Dependent Residents §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral			

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	hygiene; Based on observation, record review, and interview, the facility failed to ensure dependent residents were provided assistance with activities of daily living (ADL's) related to nail care for 2 of 10 residents reviewed for ADL's. (Residents 71 and 73) Findings include: 1. On 11/1/22 at 9:58 a.m., Resident 71 was observed in her room in bed sleeping. The fingernails on both of her hands were long and in need of trimming. On 11/3/22 at 11:45 a.m. and 2:40 p.m., the resident was in her room in bed. The fingernails on both of her hands were long and in need of trimming. Interview with the resident on 11/3/22 at 2:40 p.m., indicated she needed her fingernails trimmed. The record for Resident 71 was reviewed on 11/3/22 at 12:07 p.m. Diagnoses included, but were not limited to, stroke, rheumatoid arthritis, and weakness. The Quarterly Minimum Data Set (MDS) assessment, dated 8/30/22, indicated the resident was cognitively intact and she required extensive assistance with personal hygiene. There was no current Care Plan related to activities of daily living (ADL's). Nurses' Notes, dated 8/3/22 at 5:11 p.m., indicated the resident was alert and oriented x 2-3. Staff anticipated most of her needs. She required moderate assist in bathing and she could wash her face and hands if she was offered a towel.	F 0677	**Munster Med-Inn** **Annual Survey: 11/9/2022** Please accept the following as the facility's credible allegation of compliance. This plan of correction does not constitute an admission of guilt or liability by the facility and is submitted only in response to the regulatory requirement. **F677 ADL Care Provided for Dependent Residents** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;** Resident 71 was immediately assisted with nail care including cleaning and trimming of the hands/nails. Resident 73 was immediately assisted with nail care including cleaning and trimming of the hands/nails. **How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken;** All dependent residents have the potential to be affected by the same alleged deficient practice. **What measures will be put into place or what systemic changes will be made to ensure that the deficient**	11/21/2022

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	The Bath and Skin Report sheet, dated 10/2022, indicated the resident's nails were trimmed on 10/2, 10/5, 10/9, 10/16, 10/19, 10/23, and 10/30/22. Interview with the Director of Nursing on 11/3/22 at 2:30 p.m., indicated the resident's nails would be trimmed. 2. On 10/31/22 at 11:16 a.m. and 2:05 p.m., Resident 73 was observed in her room in bed. The resident's left hand was closed in a fist. No anti-contracture device was in use. On 11/1/22 at 11:10 a.m., the resident was observed in her broda chair in her room. The resident's left hand was closed in a fist. No anti-contracture device was in use. On 11/2/22 at 10:12 a.m., 11:43 a.m., and 1:41 p.m., the resident's left hand was closed in a fist. No anti-contracture device was in use. At 2:55 p.m., CNA 1 was observed entering the resident's room with a hand splint. The CNA removed a fleece palm protector from the resident's left hand and extended her fingers to apply the hand splint. The resident's finger nails were approximately an inch to an inch and a half long and yellow in color. There was an odor from the resident's palm as well as indentations from her fingernails. The 300 Unit Manager entered the resident's room and indicated the resident's nails would be cut. She left the room and returned with a basin of soapy water. CNA 1 attempted to soak the resident's left hand and trim her nails. She indicated she needed different nail clippers due to the resident's fingernails were not fitting in the mouth of the nail clippers. The record for Resident 73 was reviewed on		**practice does not recur;** Staff were re-educated on providing residents assistance with ADL care including general grooming, nail care, toileting, eating, and transfers as per resident's plan of care. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance programs will be put into place;** Nurse manager will randomly observe 10 residents weekly with a focus on dependent residents to ensure assistance with ADL care including grooming, nail care, toileting, eating, and transfers are provided per plan of care. Nurse manager/designee will present a summary of the audits to the Quality Assurance committee monthly for 6 months. Thereafter, if determined by the Quality Assurance committee, auditing and monitoring will be done quarterly and present quarterly at the QA meeting. Monitoring will be on going. **Date by which systemic corrections will be completed: 11/21/22**	

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11/1/22 at 4:21 p.m. Diagnoses included, but were not limited to, hemiplegia and hemiparesis (muscle weakness or partial paralysis) following a stroke, dementia with behavior disturbance, and weakness.

The Quarterly Minimum Data Set (MDS) assessment, dated 8/31/22, indicated the resident was moderately impaired for daily decision making and she required extensive assistance with personal hygiene. She also had a functional limitation in range of motion (ROM) on both sides of the upper and lower extremities.

A Care Plan, reviewed on 9/9/22, indicated the resident had hemiplegia/hemiparesis and was at risk for a decline in functional ability. Interventions included, but were not limited to, provide assistance with activities of daily living (ADL's) as needed.

The Bath and Skin Report sheet, dated 10/2022, indicated the resident was to be bathed on Monday and Thursday on the day shift. Documentation on 10/6, 10/13, 10/20, 10/24, 10/27, and 10/31/22 indicated the resident's nails had been trimmed.

Interview with the Director of Nursing on 11/3/22 at 10:40 a.m., indicated the resident's hand should have been washed and her fingernails trimmed.

3.1-38(a)(3)(E)

F 0679
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483.24(c)(1)
Activities Meet Interest/Needs Each Resident
§483.24(c) Activities.
§483.24(c)(1) The facility must provide, based on the comprehensive assessment and care plan and the preferences of each resident, an

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	ongoing program to support residents in their choice of activities, both facility-sponsored group and individual activities and independent activities, designed to meet the interests of and support the physical, mental, and psychosocial well-being of each resident, encouraging both independence and interaction in the community.			
	Based on observation, record review, and interview, the facility failed to ensure an ongoing activity program was implemented for cognitively impaired and dependent residents for 2 of 3 residents reviewed for activities. (Residents 42 and 116) Findings include: 1. On 10/31/22 at 11:16 a.m., Resident 42 was observed in his room seated in his wheel chair. He was facing the wall and the room was dark. His television was turned off. At 2:05 p.m., the resident remained in his room in his wheel chair with the television off. The resident was not doing any self-directed activities. On 11/1/22 at 9:34 a.m., the resident was seated in his wheel chair next to his bed. The resident's television was not turned on. On 11/2/22 at 10:13 a.m., the resident was seated in his wheel chair in his room. His eyes were closed and he was facing the wall. The resident's television was not turned on. At 11:43 a.m., the resident remained in his room in his wheel chair with the television turned off. The record for Resident 42 was reviewed on 11/2/22 at 10:51 a.m. Diagnoses included, but were not limited to, hemiplegia and hemiparesis (muscle weakness/partial paralysis) following a	F 0679	**Munster Med-Inn** **Annual Survey: 11/9/2022** Please accept the following as the facility's credible allegation of compliance. This plan of correction does not constitute an admission of guilt or liability by the facility and is submitted only in response to the regulatory requirement. **F679 Activities Meet Interest/Needs of Each Resident** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;** Resident 42- was re-evaluated and activities plan of care was updated as per residents' preferences. Resident 116 – was re-evaluated and activities plan of care was updated as per residents' preferences. **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;**	11/21/2022

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	stroke, dementia with behavior disturbance, and anxiety. The Quarterly Minimum Data Set (MDS) assessment, dated 8/12/22, indicated the resident was moderately impaired for daily decision making and needed supervision for locomotion on the unit. Locomotion off of the unit had not occurred during the assessment reference period. The Annual MDS assessment, dated 2/16/22, indicated the resident was moderately impaired for daily decision making. It was very important for him to have something to read, listen to music, animal visits, keep up with the news, do things with groups of people, his favorite activities, going outside, and religious services. A Care Plan, reviewed and revised on 8/23/22, indicated the resident engaged in daily self directed activities at his personal leisure. His interests were watching television, reading books, and visits with staff. The resident would attend some small group activities such as bingo and spa day. Interventions included, but were not limited to, staff would visit daily to make sure that his television and radio were in good working condition. The October 2022 Activity Calendar indicated the resident had participated in radio/tv, hydration, greetings, and wheeling/walking on 10/31/22. Interview with the Director of Nursing on 11/3/22 at 10:40 a.m., indicated the resident's television should have been turned on while he was in his room. She also indicated she would follow up with activity staff since the previous Activity Director had retired. 2. On 10/31/22 at 11:05 a.m. and 1:54 p.m., Resident 116 was observed sitting		All cognitively impaired and dependent residents have the potential to be affected by the same alleged deficient practice. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur;** Activity director and activity staff have been re-educated on providing activities according to resident preferences/needs. Activities staff was also educated on routinely re-evaluating resident activities for appropriateness and the implementation of activities appropriate for residents that are cognitively impaired and dependent on staff. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance programs will be put into place;** Activity Director/Designee will conduct weekly observations of 10 resident activities to ensue activities have been implemented for residents that are cognitively impaired and dependent residents to determine if the activity is meeting the resident preference/needs and the resident is engaged in the activity. Activity Director/designee will present a summary of the audits to the Quality Assurance committee monthly for 6 months.	

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	in a wheelchair with an over bed table in front of her. The room was dark and there was no light on. There was no television nor a radio in the room. The resident was observed staring at the wall. On 11/1/22 at 10:01 a.m., the resident was observed in bed wearing a hospital gown. She was awake and staring out the window. A television was now noted on the wall and was turned on. On 11/2/22 at 11:01 a.m., the resident was observed sitting in a wheelchair in her room. The room was dark and the television was turned on, however, the volume was very low. On 11/2/22 from 3:00 p.m. to 3:45 p.m., the resident was observed sitting in a wheelchair in front of the nurses' station. She was doing nothing but sitting and staring. There was no stimulation or activity given to the resident. At times, the resident was heard talking to herself. Staff were observed walking by the resident and repositioning the face mask if needed, however, there was no staff interaction or an activity for the resident. On 11/3/22 at 11:20 a.m. and 11:45 a.m., the resident was observed in bed wearing a hospital gown. The television was turned on. The record for Resident 116 was reviewed on 11/2/22 at 1:13 p.m. The resident was admitted to the facility on 9/23/22. Diagnoses included, but were not limited to, major depressive disorder, anxiety disorder, reduced mobility, and vascular dementia without behaviors. The Admission Minimum Data Set (MDS) assessment, dated 9/29/22, indicated the resident		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: 11/21/22**	

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was not cognitively intact. She needed extensive assist with 2 person assist for bed mobility and extensive assist with 1 person physical assist for transfers.

A Care Plan, dated 9/30/22, indicated the resident was admitted for short term rehabilitation and was able to self-initiate daily leisure needs. The resident would receive daily visits for socialization and conversation and would engage in daily self-directed activities of her interest.

An Activity Assessment, dated 9/24/22, indicated the resident's preferred style of activity was 1 to 1 visits in the morning.

A Recreational Progress Note, dated 9/24/22 at 3:52 p.m., indicated the resident was alert and extremely confused. A copy of the resident rights was placed on the board along with a weekly food menu and activity calendar.

A Recreational Progress Note, dated 11/3/22 at 9:40 a.m., indicated the resident was unable to voice her leisure needs. The resident was highly confused at times as evidenced by staff. The writer continued to greet the resident daily.

The October 2022 1 to 1 individual activity program flow sheet, indicated conversation, socialization, nail care, hand and arm massage, touch therapy, and turn on radio or television were listed as activities. Activities documented by staff were conversation, touch therapy, and turning on radio or television. There were no documented 1 to 1 visits on 10/1, 10/2, 10/4, 10/6, 10/8, 10/10, 10/15, 10/16, 10/20, 10/24, 10/29 and 10/30/22.

The October Activity Calendar indicated the

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	resident attended therapy, had radio/television, hydration, greetings, and socialization. Interview with the Director of Nursing on 11/3/22 at 2:00 p.m., indicated the resident had dementia and was temporality placed on the rehabilitation floor for therapy. During the current COVID-19 outbreak, they did not like to move residents around, so since the resident would be staying on a long term basis, she would reside on the first floor and be moved to another floor when therapy was completed. 3.1-33(a)			
F 0684 SS=D Bldg. 00	483.25 Quality of Care § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. Based on observation, record review, and interview, the facility failed to ensure geri sleeves were applied as ordered and areas of bruising were assessed and monitored for 2 of 4 residents reviewed for skin conditions, non-pressure related. (Residents 73 and 139) Findings include: 1. On 10/31/22 at 11:16 a.m. and 2:05 p.m., Resident 73 was observed in her room in bed wearing a short sleeve hospital gown. No geri sleeves were in use.	F 0684	**Munster Med-Inn** **Annual Survey: 11/9/2022** Please accept the following as the facility's credible allegation of compliance. This plan of correction does not constitute an admission of guilt or liability by the facility and is submitted only in response to the regulatory requirement. **F684 Quality of Care** **What corrective action(s) will be accomplished for those**	11/21/2022

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	On 11/2/22 at 10:12 a.m., 11:43 a.m., and 1:41 p.m., the resident was observed in her room in bed wearing a short sleeve hospital gown. No geri sleeves were in use. The record for Resident 73 was reviewed on 11/1/22 at 4:21 p.m. Diagnoses included, but were not limited to, hemiplegia and hemiparesis (muscle weakness or partial paralysis) following a stroke, dementia with behavior disturbance, and weakness. The Quarterly Minimum Data Set (MDS) assessment, dated 8/31/22, indicated the resident was moderately impaired for daily decision making and she required extensive assistance with dressing and personal hygiene. A Physician's Order, dated 4/12/22, indicated the resident was to wear geri sleeves or long sleeves at all times. They may be removed for hygiene. The 10/2022 and 11/2022 Treatment Administration Records (TAR's), indicated the order had been listed as an "FYI" (for your information) and there was nowhere on the TAR to document the geri sleeves or long sleeves had been applied as ordered. Interview with the Director of Nursing on 11/3/22 at 10:40 a.m., indicated the resident should have been wearing her geri sleeves or a long sleeve shirt. 2. On 10/31/22 at 10:30 a.m., Resident 139 was observed sitting in a wheelchair wearing short sleeves. There were many bruises observed on his right arm. On 11/3/22 at 12:30 p.m., the Second Floor Unit Manager was observed performing a skin		**residents found to have been affected by the deficient practice;** Resident 73- Geri sleeves were applied as per orders. Resident 139- Bruises were assessed and new orders were received to monitor bruises. Geri sleeves were applied as ordered. Care plan was updated accordingly. **How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken;** All residents have the potential to be affected by the same alleged deficient practice. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur;** Staff were re-educated on ensuring geri- sleeves are in place as per orders. Nurses were re-educated on assessing and documenting changes in skin condition (pressure/non-pressure), notifying physician, and obtaining orders for treatment/monitoring. Assistive clinical staff were educated on notifying the nurse of any change in skin condition. **How the corrective action(s) will be monitored to ensure the deficient practice will not**	

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	155131	A. BUILDING 00 B. WING	11/09/2022

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	assessment. The resident was noted to have many red/purple bruises to his right arm. Interview with the Second Floor Unit Manager at that time, indicated she was unaware of the bruises. The floor nurse observed the resident's skin two times a week during showers. The record for Resident 139 was reviewed on 11/2/22 at 10:00 a.m. Diagnoses included, but were not limited to, type 2 diabetes, anemia, and chronic kidney disease. The Quarterly Minimum Data Set (MDS) assessment, dated 9/27/22, indicated the resident was cognitively intact. In the last 7 days the resident received an anticoagulant medication 7 times. A Care Plan, dated 7/20/22, indicated the resident was prescribed aspirin therapy and was at risk for excessive bleeding and bruising due to the medication. The approaches were to observe for signs of active bleeding (nosebleeds, bleeding gums, petechiae, purpura, ecchymotic areas, hematoma, blood in urine, blood in stools, elevated temperature, pain in joints, and abdominal pain.). A Care Plan, dated 1/7/22, indicated there was a potential for complications related to anticoagulant therapy. The approaches were to observe for signs of active bleeding (nosebleeds, bleeding gums, petechiae, purpura, ecchymotic areas, hematoma, blood in urine, blood in stools, elevated temperature, pain in joints, and abdominal pain.). Physician's Orders, dated 8/24/22, indicated Xarelto (an anticoagulant medication) 15		**recur, i.e., what quality assurance programs will be put into place;** Facility Angels/ designee will complete observation rounds on 15 residents 3 times per week to ensure areas of bruising as assessed and new physician orders are in place, existing treatments are in place, and geri-sleeves are in place. Director of Nursing/designee will present a summary of the audits to the Quality Assurance committee monthly for 6 months. Thereafter, if determined by the Quality Assurance committee, auditing and monitoring will be done quarterly and present quarterly at the QA meeting. Monitoring will be on going. Date by which systemic corrections will be completed: 11/21/2022	

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	milligrams (mg) 1 tablet daily and Aspirin 81 mg, 1 tablet daily. Nurses' Notes, dated 11/2/22 at 9:00 a.m., indicated the resident was observed with a scab on the right medial ankle measuring 0.5 centimeters (cm) by 0.8 cm. There was no documentation or indication the resident had bruising to his right arm. The October 2022 bath skin report sheet, indicated there were no concerns with bruises checked for the resident on 10/4, 10/7, 10/11, 10/14, 10/18, 10/21, 10/25, and 10/28/22 during his baths or showers. Interview with the Director of Nursing on 11/3/22 at 2:00 p.m., indicated bruises were to be identified and monitored two times a week during showers and/or baths. 3.1-37(a)			
F 0688 SS=D Bldg. 00	483.25(c)(1)-(3) Increase/Prevent Decrease in ROM/Mobility §483.25(c) Mobility. §483.25(c)(1) The facility must ensure that a resident who enters the facility without limited range of motion does not experience reduction in range of motion unless the resident's clinical condition demonstrates that a reduction in range of motion is unavoidable; and §483.25(c)(2) A resident with limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion.			

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	§483.25(c)(3) A resident with limited mobility receives appropriate services, equipment, and assistance to maintain or improve mobility with the maximum practicable independence unless a reduction in mobility is demonstrably unavoidable.			
	Based on observation, record review, and interview, the facility failed to ensure splints were applied as ordered for 2 of 3 residents reviewed for limited range of motion (ROM). (Residents 42 and 73) Findings include: 1. On 10/31/22 at 2:05 p.m., Resident 42 was observed in his room in a wheel chair. A left hand splint was in use, however, his fingers had not been extended over the length of the splint. On 11/1/22 at 9:34 a.m., the resident was observed in his room with the left hand splint in use. Again, his fingers had not been extended over the length of the splint. On 11/2/22 at 10:13 a.m. and 11:43 a.m., the left hand splint was not in use. The resident was observed in his room at those times. The record for Resident 42 was reviewed on 11/2/22 at 10:51 a.m. Diagnoses included, but were not limited to, hemiplegia and hemiparesis (muscle weakness/partial paralysis) following a stroke, dementia with behavior disturbance, and anxiety. The Quarterly Minimum Data Set (MDS) assessment, dated 8/12/22, indicated the resident was moderately impaired for daily decision making. The resident also had a functional limitation in range of motion (ROM) on both sides	F 0688	**Munster Med-Inn** **Annual Survey: 11/9/2022** Please accept the following as the facility's credible allegation of compliance. This plan of correction does not constitute an admission of guilt or liability by the facility and is submitted only in response to the regulatory requirement. **F688 Increase/Prevent Decrease in ROM/Mobility** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;** Resident 42- splint was immediately re-evaluated by Occupation Therapy to determine correct fit. Splint was deemed appropriate fitting by OTR. Splint was applied as per physician orders. Resident 73- splint was immediately applied as per physician orders. **How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be**	11/21/2022

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	of the upper and lower extremities. A Care Plan, reviewed on 8/24/22, indicated the resident had a splint to his left upper extremity and was at risk for complications. Interventions included, but were not limited to, apply splint during day time hours and remove at bed time and provide assistance with splint application and removal as needed. The October 2022 Physician's Order Summary (POS), indicated the resident was to wear a functional position hand/wrist splint to the left upper extremity during day time hours and it was to be removed at bedtime for hygiene and skin check. Interview with the Director of Nursing on 11/3/22 at 10:40 a.m., indicated the resident's fingers should have been extended over the splint and the splint should have been applied as ordered. 2. On 10/31/22 at 11:16 a.m. and 2:05 p.m., Resident 73 was observed in her room in bed. The resident's left hand was closed in a fist. No anti-contracture device was in use. On 11/1/22 at 11:10 a.m., the resident was observed in her broda chair in her room. The resident's left hand was closed in a fist. No anti-contracture device was in use. On 11/2/22 at 10:12 a.m., 11:43 a.m., and 1:41 p.m., the resident's left hand was closed in a fist. No anti-contracture device was in use. At 2:55 p.m., CNA 1 was observed entering the resident's room with a hand splint. The CNA removed a fleece palm protector from the resident's left hand and extended her fingers to apply the hand splint. The resident's hand needed to be cleaned and her nails		**taken;** All residents with splints have the potential to be affected by the same alleged deficient practice. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur;** Nurses were reeducated on ensuring splints are in place per physician orders. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance programs will be put into place;** Nurse manager/designee will randomly audit 5 residents with splints weekly to ensure splint are in place as physician orders. Nurse manager/designee will present a summary of the audits to the Quality Assurance committee monthly for 6 months. Thereafter, if determined by the Quality Assurance committee, auditing and monitoring will be done quarterly and present quarterly at the QA meeting. Monitoring will be on going. **Date by which systemic corrections will be completed: 11/21/22**	

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trimmed before the splint could be applied.

The record for Resident 73 was reviewed on 11/1/22 at 4:21 p.m. Diagnoses included, but were not limited to, hemiplegia and hemiparesis (muscle weakness or partial paralysis) following a stroke, dementia with behavior disturbance, and weakness.

The Quarterly Minimum Data Set (MDS) assessment, dated 8/31/22, indicated the resident was moderately impaired for daily decision making. She also had a functional limitation in range of motion (ROM) on both sides of the upper and lower extremities.

A Care Plan, reviewed on 9/9/22, indicated the resident had a splint to the left hand/wrist and was at risk for complications. Interventions included, but were not limited to, provide verbal and physical guidance and direction to instruct the resident and/or caregiver on how to apply and remove the splint as needed.

The October 2022 Physician's Order Summary (POS), indicated the resident was to wear a left upper extremity functional position hand/wrist splint during waking hours following AM hygiene. The splint was to be removed at bedtime with a skin check completed following the removal of the splint.

The October 2022 Treatment Administration Record (TAR), indicated the splint had been signed out as being applied on 10/31/22.

The November 2022 TAR, indicated the splint had been signed out as being applied on 11/1/22.

Interview with the Director of Nursing on 11/3/22

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	at 10:40 a.m., indicated the resident's splint should have been applied as ordered. 3.1-42(a)(2)			
F 0692 SS=D Bldg. 00	483.25(g)(1)-(3) Nutrition/Hydration Status Maintenance §483.25(g) Assisted nutrition and hydration. (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(1) Maintains acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrates that this is not possible or resident preferences indicate otherwise; §483.25(g)(2) Is offered sufficient fluid intake to maintain proper hydration and health; §483.25(g)(3) Is offered a therapeutic diet when there is a nutritional problem and the health care provider orders a therapeutic diet.			
	Based on observation, record review, and interview, the facility failed to document meal consumption and ensure supplements were monitored for residents with a history of weight loss and/or were a nutritional risk for 3 of 7 residents reviewed for nutrition. (Residents 116, 173 and 75) Findings include: 1. On 11/3/22 at 11:45 a.m., the speech therapist	F 0692	**Munster Med-Inn** **Annual Survey: 11/9/2022** Please accept the following as the facility's credible allegation of compliance. This plan of correction does not constitute an admission of guilt or liability by the facility and is submitted only in response to the regulatory requirement. **F692 Nutrition/Hydration Status**	11/21/2022

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	was observed feeding Resident 116. The resident was served a pureed diet with thin liquids. The record for Resident 116 was reviewed on 11/2/22 at 1:13 p.m. The resident was admitted to the facility on 9/23/22. Diagnoses included, but were not limited to, major depressive disorder, anxiety disorder, reduced mobility and vascular dementia without behaviors. The Admission Minimum Data Set (MDS) assessment, dated 9/29/22, indicated the resident was not cognitively intact. The resident weighed 205 pounds with no significant weight loss. A Care Plan, dated 10/3/22, indicated the resident required a therapeutic and mechanically altered diet. The approaches were to monitor and record by mouth intake of food and weights. The resident's weights were as follows: - 9/23 205 pounds - 9/30 202 pounds - 10/7 202 pounds - 10/14 195 pounds - 10/27 190 pounds - 11/2/22 187 pounds Physician's Orders, dated 10/26/22, indicated the resident was to receive a regular puree texture diet with thin liquids. No added salt, extra gravy/sauces, and a frozen nutritional treat with lunch and dinner. A Registered Dietitian's Progress (RD) Note, dated 10/25/22, indicated the resident had a 12.8 pound weight loss and a 6.2% significant loss in 1 month. The meal consumption logs indicated breakfast		**Maintenance** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;** Resident's 75, 116, and 173- Meal consumption and nutritional supplement consumption were updated. **How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken;** All residents have the potential to be affected by the same alleged deficient practice. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur;** Nursing staff was in-serviced on documenting nutritional supplement consumption in the medical record. Nursing staff were in-serviced on documenting meal intake in Point of Care. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance programs will be put into place;** Nurse Managers will audit meal intake documentation for 10 residents in Point of Care weekly	

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	was not documented on 10/1, 10/3, 10/5, 10/6, 10/22, and 10/29/22. Lunch was not documented on 9/24, 10/1, 10/3, 10/5, 10/6, 10/22, and 10/29/22 and dinner was not documented on 9/25, 10/7, and 10/9/22. The Medication Administration Record (MAR) for 10/2022, indicated the med pass (a nutritional supplement) 120 milliliters (ml) was signed out at as being administered 10/1-10/31/22, however, there was no amount documented of how much the resident consumed. Interview with the First Floor Unit Manager on 11/3/22 at 11:30 a.m., indicated meal intakes should be completed after every meal. She was not aware the amount consumed of the house supplement was not displayed on the MAR. Interview with the Director of Nursing on 11/3/22 at 2:00 p.m., indicated the meal consumption were to be completed after every meal. The house supplement was to be completed on the MAR with the amount consumed. 2. During an interview with Resident 173 on 10/31/22 at 2:03 p.m., she indicated she had lost weight. The record for Resident 173 was reviewed on 11/1/22 at 4:12 p.m. Diagnoses included, but were not limited to, type 2 diabetes, depressive disorder, protein calorie malnutrition, and weakness. The 10/11/22 Admission Minimum Data Set (MDS) assessment, indicated the resident was cognitively intact. The resident had no oral problems and weighed 124 pounds with no		to ensure documentation compliance. Nurse Managers will audit Medication Administration Record for 10 residents weekly to ensure nutritional supplement consumption percentages are documented. The Director of Nursing/designee will present a summary of the audits to the Quality Assurance committee monthly for 6 months. Thereafter, if determined by the Quality Assurance committee, auditing and monitoring will be done quarterly and present quarterly at the QA meeting. Monitoring will be on going. **Date by which systemic corrections will be completed: 11/21/22**	

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significant weight loss noted.

A Care Plan, dated 10/19/22, indicated the resident was at risk for decreased food and fluid intake related to symptoms/side effects of active COVID-19 infection including loss of taste and smell and flu like symptoms.

The weights for the resident were as follows:
- 10/5 124 pounds
- 10/12 115 pounds
- 10/19 115 pounds
- 10/26 113 pounds
- 11/2/22 111 pounds

Physician's Orders, dated 10/10/22, indicated the resident was to receive a house supplement 120 milliliters (ml) twice a day at 9:00 a.m. and 5:00 p.m., and a regular no concentrated sweets, no added salt, regular texture and liquids diet.

A Registered Dietitian's Progress (RD) Note, dated 11/2/22, indicated the resident's current weight was 110.8 pounds which showed a significant weight loss of 10.4% in 1 month.

The meal consumption logs indicated breakfast was not documented on 10/17,10/21,10/23,10/24, 10/25, and 10/27/22. Lunch was not documented on 10/17,10/21,10/23, 10/24, 10/25, and 10/27/22, and dinner was not documented on 10/5, 10/6, 10/8, 10/9, 10/10, 10/13, 10/15, 10/19, 10/20, 10/23,10/25, and 10/28/22.

The Medication Administration Record (MAR) for 10/2022, indicated the house supplement 120 ml was signed out at being administered 10/10-10/31/22, however, there was no amount documented of how much the resident consumed.

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Interview with the Director of Nursing on 11/3/22 at 2:00 p.m., indicated the meal consumptions were to be completed after every meal. The house supplement was to be completed on the MAR with the amount consumed.

3. During an interview with Resident 75 on 10/31/22 at 10:09 a.m., she indicated she did not always get her supplements.

The record for Resident 75 was reviewed on 11/3/22 at 10:13 a.m. Diagnoses included, but were not limited to, major depressive disorder, dementia with other behaviors, osteoporosis, and anemia.

The Quarterly Minimum Data Set (MDS) assessment, dated 9/2/22, indicated the resident was cognitively intact, she weighed 131 pounds and had a significant weight loss. The resident needed supervision with set up for eating.

A Care Plan, revised 9/13/22, indicated the resident had the potential for alteration in nutrition status related to a weight loss trend. The approaches were to monitor and record intake of food and weight.

The resident's weights were as follows:
- 8/5 143 pounds
- 9/2 131 pounds
- 10/3 123 pounds
- 10/18 126 pounds
- 10/25 124 pounds
- 11/1/22 126 pounds

Physician's Orders, dated 8/22/22, indicated the resident was to receive house supplement 4 ounces twice a day.

Physician's Orders, dated 10/20/22, indicated the

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	resident was to receive a general diet with no added salt and a frozen nutritional treat at dinner. A Registered Dietitian's Progress (RD) Note, dated 10/20/22, indicated the resident's current weight on 10/3 was 123 pounds which was a 8.6 pound and 6.6% significant loss in one month, as well as a 25 pound or 16.9% significant weight loss times 3 months, and 30.6 pounds or 20% significant weight loss times 6 months. The meal consumption logs indicated breakfast was not documented on 9/7, 9/10, 9/17, 9/18, 9/20, 9/21, 9/29, 10/1, 10/2, 10/4, 10/11, 10/15, 10/20, 10/24, 10/25, and 10/29/22. Lunch was not documented on 9/7, 9/11, 9/17, 9/18, 9/19, 9/20, 9/21, 9/28, 9/29, 10/1, 10/2, 10/4, 10/11, 10/5, 10/20, 10/24, 10/25, and 10/29/22 Dinner was not documented on 9/27, 9/29, 10/2, 10/10, 10/15, 10/16, 10/28, 10/29, and 10/30/22. The Medication Administration Record (MAR) for 10/2022, indicated the house supplement 4 ounces was signed out at being administered 10/1-10/31/22, however, there was no amount documented of how much the resident consumed. Interview with the Second Floor Unit Manager on 11/3/22 at 12:30 p.m., indicated the resident was on the 4th floor for some of her stay because she had COVID-19. The food consumption intakes were to be documented after every meal. 3.1-46(a)(1)			
F 0694 SS=D Bldg. 00	483.25(h) Parenteral/IV Fluids § 483.25(h) Parenteral Fluids. Parenteral fluids must be administered consistent with professional standards of			

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MUNSTER MED-INN	7935 CALUMET AVE MUNSTER, IN 46321

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	practice and in accordance with physician orders, the comprehensive person-centered care plan, and the resident's goals and preferences. Based on observation, record review, and interview, the facility failed to ensure peripherally inserted central catheter (PICC) dressings were completed as ordered for 1 of 1 residents reviewed for parenteral fluids. (Resident 148) Finding includes: On 10/31/22 at 10:54 a.m., Resident 148 was observed with a peripherally inserted central catheter (PICC) line to her upper left arm. The dressing to the PICC line was dated 10/19/22. On 11/1/22 at 9:31 a.m., the dressing to the resident's PICC line was dated 10/19/22. On 11/2/22 at 10:14 a.m., 11:43 a.m., and 1:41 p.m., the dressing to the resident's PICC line was dated 10/19/22. On 11/3/22 at 11:37 a.m. and 2:44 p.m., the dressing to the resident's PICC line was dated 10/19/22. The record for Resident 148 was reviewed on 11/2/22 at 1:11 p.m. Diagnoses included, but were not limited to, type 2 diabetes mellitus and urinary tract infection. The Annual Minimum Data Set (MDS) assessment, dated 9/7/22, indicated the resident was cognitively intact. A Care Plan, dated 10/21/22, indicated the resident required intravenous (IV medication) and had a peripherally inserted central catheter (PICC). Potential for catheter related bloodstream	F 0694	**Munster Med-Inn** **ANNUAL SURVEY: 11/9/2022** Please accept the following as the facility's credible allegation of compliance. This plan of correction does not constitute an admission of guilt or liability by the facility and is submitted only in response to the regulatory requirement. **F694 Parenteral/IV Fluids** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:** Resident 148's peripherally inserted central catheter (PICC Line) was immediately discontinued. **How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken;** All residents with Intravenous access have the potential to be affected by the same alleged deficient practice. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:**	11/21/2022

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	infection, phlebitis, deep vein thrombosis, catheter occlusion, and catheter migration. Approaches indicated to maintain asepsis during PICC site care, maintenance, and infusion. A Physician's Order, dated 10/21/22, indicated the left upper arm single lumen PICC port dressing was to be changed weekly and as needed (prn) with transparent tape on Sunday night. The 10/2022 Treatment Administration Record (TAR), indicated the dressing change had not been signed out on 10/23, however, it was signed out as being completed on 10/30/22. Interview with the Nurse Consultant on 11/3/22 at 3:00 p.m., indicated the PICC line dressing should have been completed weekly. 3.1-47(a)(2)		Staff were educated on Intravenous access site care and completing dressing changes timely per physician orders. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance programs will be put into place;** Nurse Managers will audit residents with Intravenous access weekly to ensure dressing are changed timely and per physician orders. The Director of Nursing/designee will present a summary of the audits to the Quality Assurance committee monthly for 6 months. Thereafter, if determined by the Quality Assurance committee, auditing and monitoring will be done quarterly and present quarterly at the QA meeting. Monitoring will be on going. Date by which systemic corrections will be completed: 11/21/2022	
F 0698 SS=D Bldg. 00	483.25(l) Dialysis §483.25(l) Dialysis. The facility must ensure that residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. Based on record review and interview, the facility	F 0698	**Munster Med-Inn**	11/21/2022

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	failed to ensure a fluid restriction was monitored for 1 of 1 residents reviewed for dialysis. (Resident 154) Finding includes: The record for Resident 154 was reviewed on 11/3/22 at 12:38 p.m. Diagnoses included, but were not limited to, end stage renal disease and dependence on renal dialysis. The Admission Minimum Data Set (MDS) assessment, dated 9/16/22, indicated the resident was cognitively intact and he received dialysis. A Care Plan, dated 9/10/22, indicated the resident was dependent on dialysis and was at risk for complications of the disease process and dialysis due to the diagnosis of end stage renal disease. A Physician's Order, dated 9/13/22, indicated the resident had a fluid restriction of a total daily amount of 1500 cubic centimeters (cc). The 9/2022 and 10/2022 Medication Administration Records (MAR's) had no documentation of the resident's fluid intake. A Physician's Order, dated 11/2/22, indicated the resident had a fluid restriction with the total daily amount of 1500 milliliters (ml). Nursing 423 ml, dietary 1077 ml. Nursing 1st Shift 188 ml. Nursing 2nd Shift 188 ml. Nursing 3rd Shift 47 ml. Interview with the First Floor Unit Manager on 11/7/22 at 10:00 a.m., indicated the fluid restriction order had been clarified and documentation as of now should be completed on the MAR. The previous fluid restriction should have been documented on the MAR or in the fluid		**Annual Survey: 11/9/2022** Please accept the following as the facility's credible allegation of compliance. This plan of correction does not constitute an admission of guilt or liability by the facility and is submitted only in response to the regulatory requirement. F698 Dialysis **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;** Resident 154- Fluid consumption is being documented due to fluid restriction. **How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken;** All residents with fluid restrictions have the potential to be affected by the same alleged deficient practice. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur;** Nursing staff were in-serviced on documenting fluid intake for residents on fluid restrictions. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality**	

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	consumption section of the vitals. 3.1-37(a)		**assurance programs will be put into place;** Nurse Managers will audit meal and fluid intake documentation for 10 residents in Point of Care weekly to ensure documentation compliance. The Director of Nursing/designee will present a summary of the audits to the Quality Assurance committee monthly for 6 months. Thereafter, if determined by the Quality Assurance committee, auditing and monitoring will be done quarterly and present quarterly at the QA meeting. Monitoring will be on going. Date by which systemic corrections will be completed: 11/21/22	
F 0744 SS=D Bldg. 00	483.40(b)(3) Treatment/Service for Dementia §483.40(b)(3) A resident who displays or is diagnosed with dementia, receives the appropriate treatment and services to attain or maintain his or her highest practicable physical, mental, and psychosocial well-being.			
	Based on observation, record review, and interview, the facility failed to ensure a resident with dementia received appropriate treatment and services related to individualized interventions for behaviors and activities for 1 of 4 sampled residents reviewed for dementia care. (Resident 110) Finding includes: On 11/1/22 at 9:05 a.m., Resident 110 was	F 0744	**Munster Med-Inn** **Annual Survey: 11/9/2022** Please accept the following as the facility's credible allegation of compliance. This plan of correction does not constitute an admission of guilt or liability by the facility and is submitted only in response to the regulatory requirement. **F744 Treatments/Services for**	11/21/2022

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	observed sitting up in bed crying. She was unable to say what was upsetting her. The television was not on and there were no other activity or behavioral interventions observed in place at the time. A staff member was observed in the doorway next to the room and had not entered the room to check on the resident. On 11/1/22 from 11:35 a.m. to 11:45 a.m., the resident was observed seated in her wheelchair in the hallway. The resident was tearful and crying. She was unable to express what was upsetting her but indicated she wanted to be near someone. No staff approached the resident or attempted to implement any activity or behavioral interventions. On 11/3/22 at 11:38 a.m., the resident was observed seated in her wheelchair in the unit dining room. She was participating in a singing/video activity. The resident then became tearful and was crying. Staff approached the resident and sat by her and reminded her that lunch would be served soon. The resident continued to be tearful. Resident 110's record was reviewed on 11/2/22 at 10:51 a.m. Diagnosis included, but were not limited to, dementia with behavioral disturbance, anxiety disorder, and congestive heart failure. The Quarterly Minimum Data Set (MDS) assessment, dated 10/15/22, indicated the resident was cognitively impaired and had a diagnosis of dementia. A Care Plan, dated 9/26/22, indicated the resident experienced crying and tearfulness. There was a lack of individualized interventions related to the resident's behaviors.		**Dementia** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;** Resident 110's plan of care has been updated. **How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken;** All residents with dementia have the potential to be affected by this alleged deficient practice. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur;** Staff were educated on providing residents with individualized interventions that are appropriate and address the residents needs and behaviors. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance programs will be put into place;** Dementia Program Director will randomly audit 10 residents with a diagnosis of Dementia weekly to ensure interventions meet resident's needs. The Director of Nursing/designee will present a summary of the	

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	A Care Plan, dated 9/20/22, indicated the resident had a cognitive deficit. The interventions included to assist the resident with structured activities, however, there was a lack of individualized activity interventions related to dementia. An Admission Recreational Observation, dated 9/20/22, lacked documentation of the resident's activity interests. Interview with the Director of Nursing (DON) on 11/3/22 at 10:33 a.m., indicated she would review the resident's care plans. 3.1-37(a)		audits to the Quality Assurance committee monthly for 6 months. Thereafter, if determined by the Quality Assurance committee, auditing and monitoring will be done quarterly and present quarterly at the QA meeting. Monitoring will be on going. **Date by which systemic corrections will be completed: 11/21/22**	
F 0758 SS=D Bldg. 00	483.45(c)(3)(e)(1)-(5) Free from Unnec Psychotropic Meds/PRN Use §483.45(e) Psychotropic Drugs. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic Based on a comprehensive assessment of a resident, the facility must ensure that--- §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record;			

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	§483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and §483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order. §483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication.			
	Based on observation, record review, and interview, the facility failed to ensure a resident was free from unnecessary medications related to adequate indications for the use of an antipsychotic medication for 1 of 5 residents reviewed for unnecessary medications. (Resident 116) Finding includes: On 10/31/22 at 11:05 a.m. and 1:54 p.m., Resident 116 was observed sitting in a wheelchair with an over bed table in front of her. The room was dark	F 0758	Munster Med-Inn Annual Survey: 11/9/2022 Please accept the following as the facility's credible allegation of compliance. This plan of correction does not constitute an admission of guilt or liability by the facility and is submitted only in response to the regulatory requirement. **F758 Free from unnecessary psychotropic meds/PRN use**	11/21/2022

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	and there was no light on. There was no television nor a radio in the room. The resident was observed staring at the wall. The resident was not displaying any behaviors. On 11/1/22 at 10:01 a.m., the resident was observed in bed wearing a hospital gown. She was awake and staring out the window. The resident was not displaying any behaviors. On 11/2/22 at 11:01 a.m., the resident was observed sitting in a wheelchair in her room. The room was dark and the resident was not displaying any behaviors. On 11/2/22 from 3:00 p.m. to 3:45 p.m., the resident was observed sitting in a wheelchair in front of the nurses' station. She was doing nothing but sitting and staring. At times, the resident was heard talking to herself. Staff were observed walking by the resident and repositioning the face mask if needed. The resident was not displaying any behaviors. On 11/3/22 at 11:20 a.m. and 11:45 a.m., the resident was observed in bed wearing a hospital gown. The resident was not displaying any behaviors. The record for Resident 116 was reviewed on 11/2/22 at 1:13 p.m. The resident was admitted to the facility on 9/23/22. Diagnoses included, but were not limited to, major depressive disorder, anxiety disorder, and vascular dementia without behaviors. The Admission Minimum Data Set (MDS) assessment, dated 9/29/22, indicated the resident was not cognitively intact. In the last 7 days, the resident received an antipsychotic medication 6		**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;** Resident 116- physician was notified as well as GuideStar Psych services and resident's medications list on progress note was corrected. A diagnosis/indication of use for Seroquel was received and updated in the medical record. **How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken;** All residents receiving psychotropic medications have the potential to be affected by the same alleged deficient practice. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur;** Staff were educated on ensuring there is an appropriate diagnosis/indication for use of psychotropic medications and notification to psychiatrist for any indication of use needed. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance programs will be put into place;**	

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	times, and an antidepressant medication 6 times. The Care Plan, dated 9/29/22, indicated the resident was at risk for adverse consequence related to receiving antipsychotic/antidepressant medications routinely. Physician's Orders, dated 9/24/22, included the following: - Memantine (Namenda, a medication used for dementia) 10 milligrams (mg) daily - Quetiapine (Seroquel, an antipsychotic medication) 25 mg twice a day - Sertraline (Zoloft, an antidepressant medication) 100 mg daily An initial Psychiatric consultation by the Nurse Practitioner (NP), dated 9/30/22, indicated the resident was alert and disoriented with no signs of agitation or restlessness. There were no psychotic symptoms or anxiety noted or reported. There was no documentation of the antipsychotic medication or why it was being administered. Another NP Psychiatric Progress Note, dated 10/14/22, indicated the resident had a past history use of psychotropic medications. The plan was to treat the dementia with other behaviors by continuing the Aricept at bedtime. Continue Zoloft for major depressive disorder and continue Ativan as needed (prn) for the general anxiety disorder. There was no documentation for the use of the antipsychotic medication the resident was receiving. The resident was not receiving Aricept or Ativan.		Social Services Director/Designee will randomly audit 10 residents receiving psychotropic medications weekly to ensure there is an appopriate diagnosis/indication for use is in place. The Director of Nursing/designee will present a summary of the audits to the Quality Assurance committee monthly for 6 months. Thereafter, if determined by the Quality Assurance committee, auditing and monitoring will be done quarterly and present quarterly at the QA meeting. Monitoring will be on going. Date by which systemic corrections will be completed: 11/21/22	

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	A Social Service (SS) Progress Note, dated 10/3/22 at 2:52 p.m., indicated the resident was pleasantly confused with clear and nonsensical speech. A Social Service Progress Note, dated 11/2/22 at 11:01 a.m., indicated the resident was alert with confusion. There were no mood or behaviors observed. Interview with the First Floor Unit Manager on 11/3/22 at 11:30 a.m., indicated the resident has had no behaviors since admission. Interview with the Director of Nursing on 11/3/22 at 2:00 p.m., indicated the facility's SS Consultant indicated vascular dementia without behaviors was an acceptable diagnosis for Seroquel. She also indicated the NP from the behavioral health consult was probably looking at someone else's medication list and the antipsychotic medication was not addressed. 3.1-48(a)(4)			
F 0880 SS=D Bldg. 00	483.80(a)(1)(2)(4)(e)(f) Infection Prevention & Control §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements:			

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	§483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident			

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	contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary.			
	Based on record review and interview, the facility failed to ensure infection control guidelines were in place and implemented, including those to prevent and/or contain COVID-19, related to monitoring for COVID-19 signs and symptoms while COVID positive for 1 of 1 residents. The facility also failed to ensure a resident who was exhibiting signs and symptoms of COVID-19 was tested immediately and monitored for signs and symptoms for 1 of 1 residents who had exhibited signs and symptoms of COVID-19. (Residents 150 and 154) Findings include: 1. The record for Resident 150 was reviewed on 11/2/22 at 2:13 p.m. The resident was admitted to the facility on 6/1/22. Diagnoses included, but were not limited to stroke, respiratory failure, high blood pressure, COVID-19, chronic kidney disease, altered mental status, and dementia. The resident was admitted to the hospital on 10/19/22 and returned to the facility on 10/25/22.	F 0880	**Munster Med-Inn** **Annual Survey: 11/9/2022** Please accept the following as the facility's credible allegation of compliance. This plan of correction does not constitute an admission of guilt or liability by the facility and is submitted only in response to the regulatory requirement. **F880 Infection Prevention and Control** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;** Residents 150- completed his transmission-based precautions isolation timeframe and recovered from COVID-19. No corrective actions can be made. Resident 154- completed his	11/21/2022

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	155131	A. BUILDING 00 B. WING	11/09/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	The Quarterly Minimum Data Set (MDS) assessment, dated 9/29/22 indicated the resident was not cognitively intact. Nurses' Notes, dated 10/18/22 at 3:22 p.m., indicated the resident's appetite was poor for breakfast and lunch. Upon assessment of the resident, his lung sounds were noted with crackles and rhonchi throughout. The resident had some congestion. The resident was alert, and responsive to verbal and tactile stimuli. The head of the bed was elevated and the resident indicated he was not short of breath, however, the oxygen saturation was 86%. Vital signs were checked: temperature was 98.5, heart rate was 102, and respirations were 20. The Nurse Practitioner (NP) was notified and new orders were obtained for a STAT chest x-ray, oxygen at 2 liters per nasal cannula, and droplet/contact isolation due to symptoms of COVID-19. Nurses' Notes, dated 10/18/22 at 3:30 p.m., indicated oxygen was placed on the resident and the saturation went up to 90%. Nurses' Notes, dated 10/18/22 at 8:54 p.m., indicated the chest X-ray results were negative for pneumonia, pneumothorax, and no infiltrates. The resident was coughing up sputum that was opaque in color, and was less congested than earlier in the afternoon. The resident's temperature was 97.6 with an oxygen saturation of 95%. Nurses' Notes, dated 10/19/22 at 9:34 a.m., indicated the resident had excessive tracheal secretions. New orders were received for suction as needed. The resident was suctioned for a moderate amount of secretions times 3. Speech therapy was to evaluate the resident.		transmission-based precaution isolation timeframe and has recovered from COVID-19. No corrective actions can be made. **How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken;** All residents have the potential to be affected by the same alleged deficient practice. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur;** Staff were educated on covid testing requirements according to CMS guidelines. Nursing staff were educated on immediately COVID testing residents that develop COVID-like symptoms. Nursing staff were educated on documenting respiratory assessments for residents who are positive for COVID-19 or exhibiting symptoms of COVID-19 in the medical record. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance programs will be put into place;** DON/designee will audit 5 residents weekly exhibiting signs/symptoms COVID-19 or who	

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	A Speech Therapist Note, dated 10/19/22 at 2:08 p.m., indicated the resident had increased secretions and had to be suctioned. In addition, the resident had a decreased oxygen level, resulting in the need to be placed on 2 liters of oxygen. Upon the therapist's arrival, the resident was lying in bed and appeared distressed. The resident had an increased heart rate and presented with increased groans and was warm to touch. The Speech Therapist spoke with nursing and recommended the resident seek further treatment and be sent to the hospital. Nurses' Notes, dated 10/19/22 at 2:27 p.m., indicated the resident was sent to the emergency room. Nurses' Notes, dated 10/19/22 at 9:07 p.m., indicated the hospital was notified and informed the facility the resident was positive for COVID-19. The resident was tested for COVID-19 on 10/18/22 in the early morning as part of an outbreak testing. He tested negative. There were no other COVID-19 rapid or point of care tests performed on the resident after he began exhibiting signs and symptoms of COVID-19. Interview with the Second Floor Unit Manager on 11/2/22 at 2:35 p.m., indicated she tested the resident in the morning during the weekly testing of the residents. She indicated the resident was not retested after exhibiting signs and symptoms of COVID-19. The facility's protocol was to place the resident in isolation and make them a PUI (Person Under Investigation) for COVID-19.		are Positive for COVID- 19 to ensure testing is done per CMS guidelines and respiratory assessments are documented in the medical record. The DON/designee will present a summary of the audits to the Quality Assurance committee monthly for 6 months. Thereafter, if determined by the Quality Assurance committee, auditing and monitoring will be done quarterly and present quarterly at the QA meeting. Monitoring will be on going. **Date by which systemic corrections will be completed: 11/21/22**	

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There was no assessment of the resident's lung sounds for the midnight shift on 10/19/22. A full set of vital signs was taken one time on 10/18/22. A COVID-19 symptom assessment was completed on 10/19/22 (no time).

The current 5/11/21, "Testing for COVID-19" policy, provided by the Director of Nursing (DON) on 11/3/22 at 12:00 p.m., indicated "Residents who have signs or symptoms of COVID-19, vaccinated or not vaccinated, must be tested immediately."

Interview with the DON on 11/3/22 at 2:00 p.m., indicated they did not perform another rapid COVID-19 test on the resident.

2. The record for Resident 154 was reviewed on 11/3/22 at 2:56 p.m. The resident was admitted on 9/10/22.

The resident tested positive for COVID-19 on 10/25/22. A full set of vital signs were completed every 4 hours for the resident.

There was no assessment of the resident's respiratory status or lung sounds on 10/26 midnight shift, day shift, and evening shift, 10/29 day shift and evening shift, 10/30 day shift and evening shift,10/31 day shift and evening shift, and on 11/1/22 for the day shift.

The current and updated 2/8/22 "Long-term Care COVID-19 Clinical Guidance" policy, indicated "Increase monitoring of residents with known COVID-19 including assessment of symptoms, vital signs, oxygen saturation via pulse oximetry, and respiratory exam to identify and quickly manage serious infection."

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	Interview with the Infection Preventionist (IP) on 11/9/22 at 10:15 a.m., indicated when a resident was COVID-19 positive, vitals were completed every 4 hours and a respiratory assessment was to be completed every shift. 3.1-18(b)			