STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155131		(X2) MULTIPLE CO A. BUILDING B. WING	onstruction 00	(X3) DATE SURVEY COMPLETED 06/28/2023	
	PROVIDER OR SUPPLIE	ER	7935 C	ADDRESS, CITY, STATE, ZIP COD ALUMET AVE 'ER, IN 46321	
(X4) ID PREFIX TAG	(EACH DEFICIE	Y STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	(X5) COMPLETION DATE
F 0000 Bldg. 00	This visit was for IN00399417, IN00 and IN00410183. Complaint IN0039 the allegations are Complaint IN0039 the allegations are Complaint IN0040 related to the allegation to the allegation to the allegation to the allegation are Unrelated deficient	the Investigation of Complaints 0399633, IN00404797, IN00407209, 09417 - No deficiencies related to cited. 09633 - No deficiencies related to cited. 04797 - Federal/State deficiencies gations are cited at F686. 07209 - Federal/State deficiencies gations are cited at F690. 10183 - No deficiencies related to cited. 10283 - No deficiencies related to cited. 1039 - Federal/State deficiencies gations are cited at F690. 10183 - No deficiencies related to cited. 1049 - Federal/State deficiencies related to cited. 1059 - Federal/State deficiencies related to cited. 1059 - Federal/State deficiencies related to cited.	F 0000		
LABORATOR Rosa McG		OVIDER/SUPPLIER REPRESENTATIVE'S SIG	GNATURE VPO	TITLE	(X6) DATE 07/14/2023

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

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 discloded 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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CENTERO I OI	THE WINE WINE OF	ALL SERVICES			0.125 1.01 0,00 00,	
		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE C		(X3) DATE SURVEY	
		IDENTIFICATION NUMBER	A. BUILDING	00	COMPLETED	
		155131	B. WING		06/28/2023	
	PROVIDER OR SUPPLIED	R	7935 C	ADDRESS, CITY, STATE, ZIP COD CALUMET AVE TER, IN 46321		
(VA) ID	CUMMADY	CTATEMENT OF DESIGNATION	ID.		(Y.F.)	
(X4) ID		STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	(X5)	
PREFIX	`	NCY MUST BE PRECEDED BY FULL	PREFIX	CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		
TAG		R LSC IDENTIFYING INFORMATION	TAG	DEFICIENCE	DATE	
		reflect State Findings cited in				
	accordance with 41	10 IAC 16.2-3.1.				
	Quality review con	npleted on 7/5/23.				
F 0686	402.05/5/(4)/:)/::)					
SS=D	483.25(b)(1)(i)(ii)	- Drawart/Harl Drassure				
88-D Bldg. 00		o Prevent/Heal Pressure				
ышу. 00	Ulcer	and a morter of				
	§483.25(b) Skin I	- ·				
	§483.25(b)(1) Pre					
		nprehensive assessment of				
		cility must ensure that-				
	` '	eives care, consistent with				
		dards of practice, to prevent nd does not develop				
	•	nless the individual's clinical				
	•	strates that they were				
	unavoidable; and	suates that they were				
		n pressure ulcers receives				
	· ·	ent and services, consistent				
	1	standards of practice, to				
		prevent infection and prevent				
	new ulcers from c					
		view and interview, the facility	F 0686	Please accept the following as	the 07/07/2023	
		idents with pressure ulcers	F 0000	facility's credible allegation of	0//0//2023	
		sary treatment and services to		compliance. This plan of		
		elated to treatments not		correction does not constitute a	n	
		eted as ordered for 1 of 3		admission of guilt or liability by	• •	
	-	for pressure ulcers. (Resident		facility and is submitted only in	uio	
	C)	for pressure dicers. (Resident		response to the regulatory		
				requirement.		
	Finding includes:			requirement.		
	I manig merades.			The facility respectfully reque	sts	
	Resident C's closed	l record was reviewed on		paper compliance for this		
		n. Diagnoses included, but were		citation		
		ein-calorie malnutrition, high				
	_	d major depressive disorder.		F686 Treatment/Svcs to		
	olood pressure, and	a major depressive district.		Prevent/Heal Pressure		
	The Significant Ch	ange in Status Minimum Data		Ulcers		
i e	I The Digitilleant Cli	ange in Status Millilliani Data	1	1 010013	i	

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Set (MDS) assessment, dated 9/14/22, indicated

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Facility ID: 000056

What corrective action(s) will

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPLE	TED
		155131	B. W	ING		06/28/2	023
				CTDEET	ADDRESS, CITY, STATE, ZIP COD	<u> </u>	
NAME OF I	PROVIDER OR SUPPLIE	R			ALUMET AVE		
MUNICTE	ER MED-INN				ΓER, IN 46321		
MONSTE	EK MED-IMM			MONS	TER, IN 4032 I		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ATE	COMPLETION
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	the resident was se	verely cognitively impaired for			be accomplished for those		
	daily decision mak	ing. She required extensive			residents found to have been	n	
	assistance with one	person physical assist for bed			affected by the deficient		
	mobility, dressing,	eating, and personal hygiene.			practice;		
	She had 1 stage 4 a	equired pressure ulcer, 2			Resident C- no longer resides	in in	
	acquired unstageab	le pressure ulcers, and 4			the facility.		
	acquired deep tissu	e injuries (DTI).			How the facility will identify		
					other residents having the		
	A Care Plan, dated	6/6/22, indicated the resident			potential to be affected by the	ie	
	had an alteration in	skin integrity as evidenced by			same deficient practice and		
	pressure ulcers. Int	erventions included, but were			what corrective action will b	е	
	not limited to, treat	ments (application of			taken;		
	ointment/medication	on and/or dressings) to site per			All residents with treatment or	ders	
	Physician's order.			have the potential to be affected		ed	
					by the same alleged deficient		
	A Wound Physicia	n note, dated 6/30/22, indicated			practice.		
	the resident had a r	new unstageable DTI of the left			What measures will be put in	nto	
	heel. The wound w	as 3.5 centimeters (cm) by 4.5			place or what systemic		
	cm. The dressing to	eatment plan was to apply skin			changes will be made to		
	prep once daily for	30 days.			ensure that the deficient		
					practice does not recur;		
		or documentation of the			Staff were re-educated on the	;	
	treatment being con	mpleted for the skin prep			following:		
	application to the le	eft heel.			 Ensuring treatments are 	,	
					updated and completed per		
	-	n note, dated 8/25/22, indicated			physician orders		
		OTI to the left heel. The wound			 Treatments are properly 	,	
		y 8.0 cm. The new dressing			documented in Electronic		
	_	to apply betadine (a topical			Treatment Administration Rec	ord	
		daily with a gauze island border			(ETAR) at the time care is		
	dressing for 30 day	S.			rendered.		
					How the corrective action(s)		
		or documentation of the			will be monitored to ensure	the	
		mpleted for the betadine			deficient practice will not		
		gauze island border dressing to			recur, i.e., what quality		
	the left heel.				assurance programs will be	put	
					into place;		
	-	n note, dated 9/1/22, indicated			Wound nurse/designee will		
		OTI to the left heel. The wound			randomly audit 10 residents		
	measured 5.5 cm b	y 5.5 cm. The new dressing			Electronic Treatment	1	

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING 00 COMPLETED B. WING 06/28/2023 155131 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 7935 CALUMET AVE MUNSTER MED-INN MUNSTER, IN 46321 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE treatment plan was to apply an oil emulsion (a Administration Record (ETAR) nonstick dressing) and betadine with a gauze weekly to ensure treatments island border dressing three times per week. orders are updated and rendered as per physician orders. There was no order or documentation of the DON/designee will present a treatment being completed for the oil emulsion summary of the audits to the and betadine with a gauze island border dressing Quality Assurance committee to the left heel. monthly for 6 months. Thereafter, if determined by the Quality A Wound Physician note, dated 9/1/22, indicated Assurance committee, auditing the resident had a DTI of the left, medial ankle. and monitoring will be done The wound measured 2 cm by 1.4 cm. The quarterly and present quarterly at dressing treatment plan was to apply skin prep the QA meeting. Monitoring will once daily for 30 days. be on going. There was no order implemented until 9/8/22 for Date by which systemic the application of the skin prep to the left, medial corrections will be completed: 7/7/2023 A Wound Physician note, dated 9/1/22, indicated the resident had a DTI to the left, lower, lateral calf. The wound measured 0.9 cm x 1 cm. The dressing treatment plan was to apply skin prep once daily for 30 days. There was no order or documentation of the treatment being completed for the application of skin prep to the left, lower, lateral calf. A Wound Physician note, dated 9/15/22, indicated the resident had an unstageable DTI of the right, dorsal, medial foot. The wound measured 0.3 cm by 0.3 cm. The dressing treatment plan was to apply mupirocin (an antibiotic) ointment once daily for 30 days. There was no order or documentation of the treatment being completed for the mupirocin ointment to the right dorsal, medial foot.

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		l í	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
			A. BUILDING 00			COMPLETED	
		155131	B. WING 06/28/20		/2023		
	PROVIDER OR SUPPLIER			7935 C	ADDRESS, CITY, STATE, ZIP COD ALUMET AVE ER, IN 46321		
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
		note, dated 9/15/22, indicated					
		unstageable pressure ulcer to					
	· ·	e. The wound measured 1.7 cm					
		sing treatment plan was to					
		(an antimicrobial wound gel) border dressing once daily for					
	30 days.	border dressing once daily for					
		or documentation of the					
		npleted for the iodosorb gel					
	with a gauze island	border dressing.					
	Interview with the I	Director of Nursing on 6/28/23					
		ted the treatment orders should					
	have been updated a	and the treatments completed					
	per the Wound Care	e Physician's orders.					
	This Federal tag rela	ates to Complaint IN00404797.					
	3.1-40(a)(2)						
F 0690	483.25(e)(1)-(3)						
SS=E	, , , , , ,	continence, Catheter, UTI					
Bldg. 00	§483.25(e) Inconti	inence.					
	- ' ' ' '	facility must ensure that					
		ntinent of bladder and					
		on receives services and					
		ntain continence unless his					
		dition is or becomes such					
	that continence is	not possible to maintain.					
	§483.25(e)(2)For a	a resident with urinary					
	. , , ,	ed on the resident's					
	comprehensive as	ssessment, the facility must					
	ensure that-						
	` '	enters the facility without					
		eter is not catheterized					
		nt's clinical condition					
		catheterization was					
	necessary;						

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY			
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING				
		155131	B. WING 06/28/2023				
NAME OF I	PROVIDER OR SUPPLIER	3	7935	T ADDRESS, CITY, STATE, ZIP COD CALUMET AVE	1		
MUNSTE	ER MED-INN		MUN	STER, IN 46321			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRECTION	(X5)		
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	COMPLETION		
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)	DATE		
	, ,	enters the facility with an					
	1	er or subsequently receives					
		or removal of the catheter					
		ole unless the resident's					
		demonstrates that					
	catheterization is						
		o is incontinent of bladder					
		ate treatment and services					
		tract infections and to					
	restore continence	e to the extent possible.					
	\$493.25(a)(3) For	a resident with fecal					
	. , , ,	ed on the resident's					
		ssessment, the facility must					
	1	dent who is incontinent of					
		ppropriate treatment and					
		e as much normal bowel					
	function as possib						
	•	view and interview, the facility	F 0690	Please accept the following a	s the $07/07/2023$		
		rsing staff provided foley	1 0000	facility's credible allegation of			
		are every shift for 4 of 4		compliance. This plan of			
	1	for catheters. (Residents F, J,		correction does not constitute	an		
	K, and D)	, ,		admission of guilt or liability b			
	, ,			facility and is submitted only i	· I		
	Findings include:			response to the regulatory			
				requirement.			
	1. On 6/26/23 at 1:	08 p.m., Resident F was		The facility respectfully requ	uests		
		m in bed sleeping. She had a		paper compliance for this			
	foley catheter in us	e that was draining yellow		citation			
	urine.						
				F690 Bowel/Bladder			
		dent F was reviewed on		Incontinence, Catheter, UTI			
	6/26/23 at 2:15 p.m	Diagnoses included, but were		What corrective action(s) wi	II		
	_	sure ulcer of the sacral region		be accomplished for those			
	and disorders of the	e kidney and ureter.		residents found to have bee	n		
				affected by the deficient			
	•	e Minimum Data Set (MDS)		practice;			
		5/23/23, indicated the resident		Resident D – Catheter care o	rders		
		paired for daily decision		reviewed and being documen	ted		
	making. She requir	red extensive assistance with		appropriately			

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING COMPLETED 00 B. WING 06/28/2023 155131 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 7935 CALUMET AVE MUNSTER MED-INN MUNSTER, IN 46321 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE toilet use and had an indwelling catheter. Resident F- Catheter care orders reviewed and being documented A Care Plan, dated 6/7/23, indicated the resident appropriately had a urinary catheter due to a stage 4 coccyx Resident K- Catheter care orders wound. Interventions included, but were not reviewed and being documented limited to, observe for signs and symptoms of a appropriately urinary tract infection: pain, burning, blood Resident J- Catheter care orders tinged urine, cloudiness, no output, deepening of reviewed and being documented urine color, increased pulse, increased appropriately temperature, urinary frequency, foul smelling How the facility will identify urine, fever, chills, altered mental status, change in other residents having the behavior, and change in eating patterns. potential to be affected by the same deficient practice and A Physician's Order, dated 4/30/23, indicated the what corrective action will be resident was to have a 16 french/10 milliliter (ml) taken; foley catheter. Catheter care was to be completed All residents with indwelling every shift and as needed. catheters have the potential to be affected by the same alleged A Physician's Order, dated 6/9/23, indicated the deficient practice. resident was to receive Keflex (an antibiotic) 500 What measures will be put into milligrams (mg) twice a day for a urinary tract place or what systemic infection until 6/16/23. changes will be made to ensure that the deficient The May 2023 Treatment Administration Record practice does not recur; (TAR), indicated catheter care had not been Staff were re-educated on: signed out all three shifts between 5/18 and Ensuring catheter care 5/21/23. orders are in place for residents with catheters The June 2023 TAR, indicated catheter care had Documenting catheter care not been signed out as being completed during in Point Click Care at the time the day shift on 6/2, 6/5, 6/12, 6/21, and 6/26/23. care is rendered Catheter care had not been signed out on the How the corrective action(s) evening shift on 6/7, 6/11, 6/12, 6/21, and 6/24/23. will be monitored to ensure the deficient practice will not Interview with the Director of Nursing on 6/28/23 recur, i.e., what quality at 11:25 a.m., indicated a problem was identified assurance programs will be put last week related to Medication Administration into place; Records (MAR's) and TAR's not being signed out Nurse Managers will audit the as being completed. The staff were inserviced on **Electronic Treatment Record** Monday 6/26/23. 2. Resident J's record was (ETAR) 2 times per week for

PRINTED: 07/25/2023

EPARTMENT OF HEALTH AND HUMAN SERVICES							FORM APPROVED	
ENTERS FOR	R MEDICARE & MEDICA	AID SERVICES			OM	B NO. 0938-039		
STATEMEN	IT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MU	X2) MULTIPLE CONSTRUCTION (X3) DATE S			SURVEY	
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPLETED		
		155131	B. WI	B. WING			06/28/2023	
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD				
				7935 CALUMET AVE				
MUNSTE	R MED-INN			MUNST	ER, IN 46321			
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION	
TAG	DECLII ATODV OD	I SC IDENTIEVING INFORMATION		TAC	DEFICIENCY)	16	DATE	

MUNST	ER MED-INN	MUNS	TER, IN 46321	
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	(EACH DEFICIENCY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	COMPLETION
TAG	REGULATORY OR LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)	DATE
	reviewed on 6/26/23 at 1:47 p.m. Diagnoses		residents with foley catheters to	
	included, but were not limited to, neuromuscular		ensure documentation is	
	dysfunction of the bladder and history of urinary		completed.	
	tract infection.		The Director of Nursing/designee	
			will present a summary of the	
	The Discharge Minimum Data Set (MDS)		audits to the Quality Assurance	
	assessment, dated 6/4/23, indicated the resident		committee monthly for 6 months.	
	was severely impaired for daily decision making.		Thereafter, if determined by the	
	The resident had an indwelling catheter and was		Quality Assurance committee,	
	frequently incontinent of bowel. She required		auditing and monitoring will be	
	extensive assistance with toilet use and personal		done quarterly and present	
	hygiene.		quarterly at the QA meeting.	
			Monitoring will be on going.	
	A Care Plan, dated 10/21/19, indicated the resident		Date by which systemic	
	required a suprapubic catheter. Interventions		corrections will be completed:	
	included, but were not limited to, change foley		7/7/2023	
	and catheter bag as per orders.			
	A Physician's Order, dated 5/24/23, indicated catheter care every shift.			
	The Treatment Administration Record (TAR) for			
	May 2023, indicated the resident's catheter care			
	was not completed as ordered on the day shift on			
	5/31/23. It was not completed on the evening shift			
	on 5/25/23, 5/28/23, and 5/31/23. It was not			
	completed on the night shift of 5/29/23.			
	The TAR for June 2023, indicated the resident's			
	catheter care was not completed as ordered on the			
	day shift on 6/3/23, 6/5/23, 6/6/23, 6/7/23, 6/8/23,			
	and 6/9/23. It was not completed on the evening			
	shift on 6/4/23, 6/5/23, 6/6/23, 6/7/23, and 6/8/23. It			
	was not completed on the night shift on 6/1/23,			
	6/2/23, 6/4/23, 6/5/23, 6/6/23, 6/7/23, 6/8/23,			
	6/10/23, 6/15/23, and 6/24/23.			
	Interview with the Director of Nursing on 6/27/23			
	at 3:15 p.m., indicated there were blanks on the			
	Treatment Administration Record, however she			

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	AND PLAN OF CORRECTION IDENTIFICATION NUMBER		A. BU	JILDING	00	COMPI	
		155131	B. W	ING		06/28	/2023
NAME OF D	PROVIDER OR SUPPLIER	2	-	STREET A	ADDRESS, CITY, STATE, ZIP COD		
					ALUMET AVE		
MUNSTE	ER MED-INN			MUNST	TER, IN 46321		
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	1	NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE.	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION	+	TAG	DEFICIENCY)		DATE
		ust not signed out due to the over to a new electronic health					
	record (EHR) syste						
	l record (Errit) system						
	3. Resident K's reco	ord was reviewed on 6/28/23 at					
	9:03 a.m. Diagnose	es included, but were not limited					
	_	pinal cord and history of					
	urinary tract infecti	on.					
	A Care Plan dated	5/3/23, indicated the resident					
		eatheter for neurogenic bladder					
	_	infection. Interventions					
	included, but were	not limited to, provide catheter					
	care and monitor/do	ocument for pain/discomfort					
	during care to the c	atheter.					
	A Dhygiaian's Orda	r, dated 5/1/23, indicated					
	catheter care every						
		atment Administration Record					
	1 '	e resident's catheter care was					
		he day shift on 6/3/23, 6/10/23,					
		nd 6/25/23. The catheter care					
	_	on the evening shift on 6/7/23					
	on the night shift or	atheter care was not completed					
	I -	0:25 a.m., Resident D was					
		om in bed. The resident had a					
		e that was draining yellow					
		was noted in the tubing.					
		resident at that time, indicated					
	foley catheter care	was "hit or miss" and it worried					
		ry of urinary tract infections					
	and sepsis.						
	The record for Resi	ident D was reviewed on					
		a. Diagnoses included, but were					
		rder of the kidney and ureter					
	and urinary tract in	-					

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DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 07/25/2023 FORM APPROVED OMB NO. 0938-039

	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155131	(X2) MULT A. BUILI B. WING		NSTRUCTION 00	(X3) DATE COMPL 06/28/	ETED
	PROVIDER OR SUPPLIEF	.	7	935 CA	DDRESS, CITY, STATE, ZIP COD LLUMET AVE ER, IN 46321		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	PRI	D EFIX AG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
	assessment, dated 4	imum Data Set (MDS) 1/11/23, indicated the resident act and had an indwelling					
	had an indwelling of sacral pressure ulce were not limited to, symptoms of UTI s tinged urine, cloudi urine color, increas temperature, urinar urine, fever, chills,	6/26/23, indicated the resident eatheter related to having a er. Interventions included, but observe for signs and such as pain, burning, blood mess, no output, deepening of ed pulse, increased y frequency, foul smelling altered mental status, change in ge in eating patterns.					
	indicated the reside	d 5/31/23 at 2:04 p.m., nt's foley catheter was not was irrigated and urine flow					
	indicated the reside	d 6/10/23 at 11:22 a.m., nt had a new foley catheter previous one leaking.					
	resident was to hav with a 30 milliliter	dated 6/26/23, indicated the e a 22 french foley catheter (ml) balloon. Change as needed as to be performed every shift.					
	· ·	dication and Treatment cords had no orders for the catheter care.					
		atment Administration Record are foley catheter or catheter					
		Director of Nursing on 6/28/23 ated the orders did not get					

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i i		(X2) MULTIPL	(X3) DATE SURVEY		
AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155131		A. BUILDING	COMPLETED		
		155131	B. WING		06/28/2023
NAME OF PROVIDER OR SUPPLIER MUNSTER MED-INN		793	EET ADDRESS, CITY, STATE, ZIP COD 5 CALUMET AVE NSTER, IN 46321		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	•	CY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROP	E COMPLETION
TAG		LISC IDENTIFYING INFORMATION	TAG	DEFICIENCY)	DATE
	and the orders were	om the old computer system added on 6/26/23.			
	This Federal tag rela	ates to Complaint IN00407209.			
	3.1-41(a)(2)				
F 0695 SS=D Bldg. 00	Suctioning § 483.25(i) Respir tracheostomy care The facility must eneeds respiratory tracheostomy care is provided such oprofessional stand comprehensive pethe residents' goal 483.65 of this sub Based on observation interview, the facility obtained for oxygeninfusing at the corrective reviewed for oxygeninfusing includes: On 6/26/23 at 1:08 pwas observed in her had oxygen by the value of the oxygen concentry of the oxygen concentry of 6/27/23 at 10:04 in use and the residuset at 1 1/2 liters. On 6/28/23 at 10:45	e and tracheal suctioning, eare, consistent with lards of practice, the erson-centered care plan, ls and preferences, and part. on, record review, and ty failed to ensure orders were a use and the oxygen was ext flow rate for 1 of 1 residents	F 0695	Please accept the following facility's credible allegation of correction does not constitute admission of guilt or liability facility and is submitted only response to the regulatory requirement. The facility respectfully response compliance for this citation F695 Respiratory/Tracheos Care and Suctioning What corrective action(s) where the compliance for those residents found to have be affected by the deficient practice;	te an by the in quests stomy

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DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-039 STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING COMPLETED 00 B. WING 06/28/2023 155131 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 7935 CALUMET AVE MUNSTER MED-INN MUNSTER, IN 46321 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX PREFIX COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL DEFICIENCY) TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DATE Resident F- Oxygen flow rate was The record for Resident F was reviewed on immediately corrected. 6/26/23 at 2:15 p.m. Diagnoses included, but were Resident F- Oxygen orders were not limited to, heart failure, pneumonia, and acute obtained on 6/27/23. respiratory distress. 6/27/23 Staff were educated on obtaining a physician's order for The 5 day Medicare Minimum Data Set (MDS) oxygen. assessment, dated 5/23/23, indicated the resident How the facility will identify was moderately impaired for daily decision other residents having the making. Oxygen use was not coded. potential to be affected by the same deficient practice and The resident had no care plan related to oxygen what corrective action will be taken: All residents receiving oxygen A Physician's Order, dated 6/27/23, indicated the have the potential to be affected resident was to have oxygen by the way of a nasal by the same alleged deficient cannula at 2 liters per minute continuously. practice. What measures will be put into Interview with the Director of Nursing on 6/28/23 place or what systemic at 11:25 a.m., indicated the order for the resident's changes will be made to oxygen was obtained yesterday and the order for ensure that the deficient was 2 liters. practice does not recur: Staff were re-educated on: 3.1-47(a)(6) Ensuring a physician order is obtained/in-place for oxygen. Oxygen is administered at the correct flow rate. Oxygen tubing is changed and labeled appropriately. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance programs will be put into place; Nurse Managers will audit 5

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residents with oxygen 2 times per week to ensure oxygen orders are in place and oxygen is set at the

appropriate flow rate.

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DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

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	T OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155131	(X2) MULTIPL A. BUILDING B. WING	e construction g <u>00</u>	(X3) DATE COMPI 06/28	
	ROVIDER OR SUPPLIER		793	EET ADDRESS, CITY, STATE, ZIP COD 5 CALUMET AVE NSTER, IN 46321		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPRO DEFICIENCY)) BE	(X5) COMPLETION DATE
				Director of Nursing/design present a summary of the to the Quality Assurance committee monthly for 6 m. Thereafter, if determined be Quality Assurance commit auditing and monitoring will done quarterly and presen quarterly at the QA meetin Monitoring will be on going Date by which systemic corrections will be completely 1/1/2023	audits conths. cy the tee, II be t	

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