

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155131	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 09/08/2016
--	---	---	---

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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	<p>This visit was for the Investigation of Complaint IN00209511.</p> <p>Complaint IN00209511 - Substantiated. Federal/State deficiencies related to the allegation are cited at F323.</p> <p>Survey date: September 8, 2016</p> <p>Facility number: 000056 Provider number: 155131 AIM number: 100289450</p> <p>Census bed type: SNF: 24 SNF/NF: 170 Total: 194</p> <p>Census payor type: Medicare: 24 Medicaid: 110 Other: 60 Total: 194</p> <p>Sample: 3</p> <p>This deficiency reflects State findings cited in accordance with 410 IAC 16.2-3.1.</p> <p>Quality review completed by 32883 on</p>	F 0000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155131		X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____		X3) DATE SURVEY COMPLETED 09/08/2016	
NAME OF PROVIDER OR SUPPLIER MUNSTER MED-INN				STREET ADDRESS, CITY, STATE, ZIP CODE 7935 CALUMET AVE MUNSTER, IN 46321			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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 0323 SS=D Bldg. 00	<p>9/11/16.</p> <p>483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. Based on observation, record review, and interview, the facility failed to provided adequate supervision to prevent injury related to the use of a mechanical lift device not performed with two staff members as required resulting in injury for 1 of 3 residents reviewed for injuries in a sample of 3. (Resident #D)</p> <p>Finding includes:</p> <p>On 9/8/16 at 8:47 a.m., Resident #D was observed in bed. The resident had a geri sleeve (glove to protect the skin) on her right hand.</p> <p>On 9/8/16 at 11:25 a.m., the Plan of Care card for the resident was observed on the inside door of her closet. The card indicated a Sit to Stand device was to be utilized to transfer the resident.</p>	F 0323	<p>Please accept the following as the facility's plan of correction. This plan of correction does not constitute an admission of guilt or liability by the facility and is submitted only in response to the regulatory requirement. What corrective action which will be accomplished for those residents found to have been affected by the deficient practice.</p> <p>1.Nursing staff were educated on performing safe resident care transfers.</p> <p>How the facility will identify other residents having the potential to be affected by the same deficient practice All residents who require transfer assistance have the potential to be affected by the same alleged deficient practice. What measures will the facility will take or systems the facility will</p>	09/16/2016			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155131		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 09/08/2016	
NAME OF PROVIDER OR SUPPLIER MUNSTER MED-INN				STREET ADDRESS, CITY, STATE, ZIP CODE 7935 CALUMET AVE MUNSTER, IN 46321			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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			
	<p>The record for Resident #D was reviewed on 9/8/16 at 10:49 a.m. The resident's diagnoses included, but were not limited to, epilepsy, diabetes mellitus, Parkinson's disease, and high blood pressure.</p> <p>Review of the 6/4/16 Minimum Data Set (MDS) quarterly assessment indicated the resident required extensive assistance of two staff members for bed mobility and transfers. The assessment indicated the resident had impairment in range of motion on both of her lower extremities.</p> <p>A Care Plan initiated on 3/15/16 indicated the resident had limited functional status in regard to ability to transfer herself. The Care Plan was last reviewed on 6/24/16. Care Plan interventions included, but were not limited to, staff to ensure proper transfer technique was used.</p> <p>The 8/2016 Nursing Progress notes were reviewed. An entry made on 8/27/16 at 7:30 p.m. indicated the resident was observed on the floor in the room sitting on her bottom. The CNA called the Nurse to the room and the resident was observed sitting on her bottom. Skin tears were observed and bleeding also noted. The Physician was notified and new</p>		<p>alter to ensure that the problem will be corrected and will not recur. DON/Designee conducted educational training with licensed staff and unlicensed staff on the following:</p> <p>1.Performing safe resident care transfers</p> <p>How will the corrective action be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place? DON/Designee will randomly observe two resident transfers on first shift, two resident transfers on second shift and one resident transfer on third shift weekly to ensure residents are transferred properly and the correct equipment is used.Any staff observed performing incorrect transfer procedures or not having correct equipment will be provided additional education. DON/Designee will present a summary of audits to the QA committee monthly x 6 months. After 6 months, it will be determined by the Quality Assurance committee if further monitoring should continue and for what time period.</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155131	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 09/08/2016
--	---	---	---

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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
	<p>orders were obtained to apply steri strips to the skin tears.</p> <p>A Fall Event note was initiated on 8/27/16 at 7:30 p.m. The note indicated a CNA was transferring the resident using a Sit to Stand lift device in the resident's room. The resident was sliding while being transferred with the Sit to Stand lift and was eased to the floor on her bottom. Skin tears were observed on the resident's right forearm and hand. The skin tears on the right forearm measured 4.5 cm (centimeters) x 4.5 cm and 2.5 cm x 0.1 cm. The skin tears on the resident's right hand measured 1.5 cm x 2.0 cm and 4.5 cm x 3.5 cm.</p> <p>Review of the 8/27/16 "Fall Scene Investigation Report" indicated the resident slid to the floor with the assistance of a CNA while transferring the resident to bed using the Sit to Stand lift. The report indicated the CNA was alone with the resident.</p> <p>When interviewed on 9/8/16 at 11:22 a.m., CNA #2 indicated two staff members were to be present when any resident was transferred using the Sit to Stand Lift device.</p> <p>When interviewed on 9/8/16 at 1:00 p.m., the Restorative Nurse indicated she</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155131	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 09/08/2016
--	---	--	---

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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
	<p>completed the fall investigation. The Restorative Nurse indicated CNA #1 was interviewed related to the transfer and the CNA indicated she had transferred Resident #D using the Sit to Stand lift by herself. The CNA indicated she was aware and had been trained on the requirement for two staff members to assist in lift transfers.</p> <p>When interviewed on 9/8/16 at 1:30 p.m., Occupational Therapy staff #1 indicated she completed a screening on Resident #D after they were notified the resident had slid to floor while staff were transferring the resident using the sit to stand lift. The staff member indicated she observed staff members transferring the resident without difficulty or problems. The staff member indicated she had not been informed the resident was transferred with by only one staff member when the fall occurred. The staff member indicated two staff members were required while using the Sit to Stand lift.</p> <p>When interviewed on 9/8/16 at 1:45 p.m., the Director of Nursing indicated there should have been two staff present when Resident #D was transferred on 8/27/16 and at all times.</p> <p>The facility policy titled "Lifting</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155131	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 09/08/2016
--	---	---	---

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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
	<p>Machine, Using a Portable" was reviewed on 9/8/16 at 12:10 p.m. The policy had revised date of August 2008. The Director of Nursing provided the policy and indicated the policy was current. The policy indicated the "portable lift should be used by two staff members."</p> <p>This Federal tag relates to Complaint IN00209511.</p> <p>3.1-45(a)(2)</p>			