| STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155131 | | A. BU | (X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING | | (X3) DATE SURVEY COMPLETED 10/22/2024 | | |
|--|--|--|--|---|---|----|----------------------------|
| | ROVIDER OR SUPPLIER R MED-INN | | | 7935 C | ADDRESS, CITY, STATE, ZIP COD ALUMET AVE ER, IN 46321 | | |
| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION | | | ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | | TE | (X5) COMPLETION DATE |
| F 0000 Bldg. 00 | This visit was for a Licensure Survey. The Investigation of Continuous Investigated to the allegated to the allegated Investigated Investi | Recertification and State This visit included the implaints IN00444806, N00445179. 1806 - Federal/state deficiencies tions are cited at F689. 1914 - Federal/state deficiencies tions are cited at F689. 1779 - Federal/state deficiencies tions are cited at F689 and 180056 18131 189450 18016 - Federal/state deficiencies tions are cited at F689 and 18017 - Federal/state deficiencies tions are cited at F689 and 18018 - Federal/state deficiencies tions are cited at F689 and 18018 - Federal/state deficiencies tions are cited at F689 and 18019 - Federal/state deficiencies tions are cited at F689 and 18019 - Federal/state deficiencies tions are cited at F689 and 18019 - Federal/state deficiencies tions are cited at F689 and | F 00 | | The facility respectfully request paper compliance for this citat | | |

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

(X6) DATE

shanika Willhite Administrator 11/08/2024

Any defiency statement 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 disclodays 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.

FORM CMS-2567(02-99) Previous Versions Obsolete Event ID: 2HNN11 Facility ID: 000056 If continuation sheet Page 1 of 49

| STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155131 | | ì í | LDING | ONSTRUCTION 00 | (X3) DATE SURVEY COMPLETED 10/22/2024 | | |
|--|---|---|--------|---------------------|---|---|----------------------------|
| | | 100101 | B. WIN | _ | | 10/22/ | 72024 |
| | PROVIDER OR SUPPLIE ER MED-INN | R | | 7935 C | ADDRESS, CITY, STATE, ZIP COD CALUMET AVE TER, IN 46321 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIE) | STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION | I | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY) | TE | (X5) COMPLETION DATE |
| F 0550 SS=D Bldg. 00 | 483.10(a)(1)(2)(b | | | | | | |
| ыdg. UU | interview, the facil resident's dignity we exposed from the orgown while in bed residents reviewed and 92) Findings include: 1. On 10/15/24 at p.m., Resident 91 win his wheelchair. shirt and an incontibed was located ne room was open. The hallway. On 10/17/24 at 10: seated in his wheel shirt and his inconting resident's room was the hallway. The record for Res 10/17/24 at 10:36 a were not limited to with behavior distributed in the was moderately im and required partial lower body dressing. | | F 05. | 50 | Munster Med INN Complaint Survey: 10/22/2024 Please accept the following as facility's credible allegation of compliance. This plan of correction does not constitute admission of guilt or liability by facility and is submitted only in response to the regulatory requirement. F550 Resident Rights/Exercis Rights What corrective action(s) will accomplished for those reside found to have been affected by deficient practice. R91's and 120's preference to wear a brief only while in room was maintained and the curtain was immediately closed to profor privacy R92's plan of care was update reflect residents' preference to wear a facility gown while in be R91's Plan of care was update reflect the residents' preference was update reflect the residents preference was update reflect the residents of the residents of the potential be affected by the same deficience and what corrective and what corrective and will be taken; All residents have the potential be affected by the alleged definition. How the facility will identify of the same deficience and what corrective and what measures will be put into the potential be affected by the alleged definition. | an y the n e of oe ents y the on in ovide ed to oe et o ent to ient to cicient ocicient | 11/08/2024 |
| I | I The resident did no | ot have a current care plan | ı | | place or what systemic change | es | 1 |

| STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA | | (X2) MULTIPLE CONSTRUCTION (X3) DATE SUI | | | SURVEY | | |
|--|-----------------------|--|-------|---------|---|--------|------------|
| AND PLAN | OF CORRECTION | IDENTIFICATION NUMBER | A. BU | JILDING | 00 | COMPL | ETED |
| | | 155131 | B. W | NG | | 10/22/ | 2024 |
| | | | | CTD FET | ADDRESS OF A STATE SID COD | | |
| NAME OF P | ROVIDER OR SUPPLIER | 8 | | | ADDRESS, CITY, STATE, ZIP COD | | |
| NALINIOTE | D MED ININ | | | | ALUMET AVE | | |
| MUNSIE | R MED-INN | | | MUNSI | TER, IN 46321 | | |
| (X4) ID | SUMMARY | 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 DEFICIENCY) | TE | COMPLETION |
| TAG | REGULATORY OF | R LSC IDENTIFYING INFORMATION | | TAG | DEFICIENCY) | | DATE |
| | related to not weari | ng pants while in his room. | | | will be made to ensure that the | e | |
| | | | | | deficient practice does not rec | :ur; | |
| | During an interview | on 10/18/24 at 11:14 a.m., the | | | Staff were re-educated on: | | |
| | Assistant Director of | of Nursing indicated the | | | · Providing for resident privacy | / | |
| | resident should hav | e had a care plan noting that | | | · Updating the residents' | • | |
| | he liked to wear a s | hirt and brief at times. | | | preferences to their plan of ca | re | |
| | | | | | How the corrective action(s) w | | |
| | | | | | monitored to ensure the defici- | | |
| | 2. On 10/15/24 at 1 | 0:34 a.m., 11:10 a.m. and 3:11 | | | practice will not recur, i.e., who | at | |
| | p.m., Resident 120 | was observed in his room in | | | quality assurance programs w | | |
| | bed. The resident v | vas wearing a t-shirt and an | | | put into place. | | |
| | incontinence brief. | His legs were not covered, the | | | Facility Angel's will audit 10 | | |
| | privacy curtain was | n't pulled, and he was visible | | | residents 3 times per week to | | |
| | from the hallway. | | | | ensure privacy is maintained a | and | |
| | | | | | residents who prefer to always | 3 | |
| | On 10/16/24 at 11:1 | 18 a.m. and 3:59 p.m., the | | | wear gowns while in bed, | | |
| | resident was observ | red in his room in bed. He was | | | preferences are updated in the | eir | |
| | wearing a t-shirt and | d an incontinence brief. His | | | plan of care. | | |
| | | ed, the privacy curtain wasn't | | | Director of Nursing/designee v | vill | |
| | pulled, and he was | visible from the hallway. | | | present a summary of the aud | its | |
| | | | | | to the Quality Assurance | | |
| | | 12 a.m., 11:35 a.m. and 2:14 p.m., | | | committee monthly for 6 mont | hs. | |
| | | served in his room in bed. He | | | Thereafter, if determined by th | ne | |
| | _ | rt and an incontinence brief. | | | Quality Assurance committee, | | |
| | | overed, the privacy curtain | | | auditing and monitoring will be |) | |
| | wasn't pulled, and h | ne was visible from the hallway. | | | done quarterly and present | | |
| | | | | | quarterly at the QA meeting. | | |
| | | 5 a.m., the resident was | | | Monitoring will be on going. | | |
| | | m in bed. He was wearing a | | | Date by which systemic | | |
| | | tinence brief. His legs were | | | corrections will be completed: | | |
| | - | vacy curtain wasn't pulled, | | | 11/8/2024 | | |
| | and he was visible t | from the hallway. | | | | | |
| | | 1 . 100 | | | | | |
| | | dent 120 was reviewed on | | | | | |
| | | n. Diagnoses included, but | | | | | |
| | | dementia with behavior | | | | | |
| | | otic disorder with delusions, | | | | | |
| | | pulmonary disease (COPD), | | | | | |
| | and oxygen depend | ent. | | | | | |
| | | | | | | | |

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

2HNN11 Facility ID: 000056

If continuation sheet Page 3 of 49

| | Γ OF HEALTH AND HUI R MEDICARE & MEDIC | | | | | | TED: 11/19/2024 RM APPROVED IB NO. 0938-039 | |
|--------------------------|---|--|-------|--|--|-----------|---|--|
| STATEMEN | NT OF DEFICIENCIES OF CORRECTION | XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155131 | A. BU | (X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING | | | (X3) DATE SURVEY COMPLETED 10/22/2024 | |
| | PROVIDER OR SUPPLIEF | 2 | | 7935 C | ADDRESS, CITY, STATE, ZIP COD ALUMET AVE 'ER, 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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPR DEFICIENCY) | E IATE | (X5) COMPLETION DATE | |
| | assessment, dated 7 was moderately improved was moderately improved a gown, while in his but were not limited with dignity. During an interview Assistant Director of see if the resident with to reflect that. 3. D 10/16/24 at 10:12 a 9:35 a.m., 11:25 a.m. at 9:10 a.m. and 11: observed lying in both The record for Resi 10/17/24 at 9:58 a.m. not limited to, prote intermittent explosi pressure, post traun | mum Data Set (MDS) 7/11/24, indicated the resident paired for daily decision 5/24/24, indicated the resident ruly a brief, no other clothing or res room. Interventions included, resident to be provided of Nursing indicated he would rould want the privacy curtain recare plan would be updated ruring random observations on r.m. and 3:41 p.m., on 10/17/24 at r.m., and 2:10 p.m., and on 10/18/24 red a.m., Resident 92 was red wearing a hospital gown. dent 92 was reviewed on r. Diagnoses included, but were rein calorie malnutrition, red disorder, high blood reatic stress disorder (PTSD), ar disorder, and intellectual | | | | | | |

The Quarterly Minimum Data Set (MDS) assessment, dated 8/22/24, indicated the resident was not cognitively intact for daily decision making and was dependent on staff for dressing.

There was no care plan that the resident preferred to wear a hospital gown during the day time.

During an interview on 10/18/24 at 10:30 a.m., CNA 1 indicated she did not dress the resident in street clothes today, but indicated he did have

> Page 4 of 49 Event ID: 2HNN11 Facility ID: 000056 If continuation sheet

| STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155131 | | (X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING (X3) DATE SURVEY COMPLETED 10/22/2024 | | | | | |
|--|---|---|---|---|---|--|--|
| | PROVIDER OR SUPPLIER | | STREET ADDRESS, CITY, STATE, ZIP COD 7935 CALUMET AVE MUNSTER, IN 46321 | | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIEN | STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPE DEFICIENCY) | COMPLETION | | |
| F 0623 SS=A Bldg. 00 | clothes to wear. During an interview Second Floor Unit I Service was response care plans regarding gowns. During an interview Social Service Directly plan for the resident gown during the day 3.1-3(t) 483.15(c)(3)-(6)(8) Notice Requirement Transfer/Discharg Based on record reversible to ensure the was notified in writh hospital for 2 of 3 responsible to the second reversible to the second | on 10/18/24 at 10:35 a.m., the Manager indicated Social sible for updating all of the gresidents wearing hospital on 10/18/24 at 10:37 a.m., the ctor indicated there was no care to be dressed in a hospital y. onts Before eview and interview, the facility resident's Responsible Party ing related to a transfer to the esidents reviewed for esidents 7 and 16) esident 7 was reviewed on m. Diagnoses included, but type 2 diabetes, left below the eripheral vascular disease | F 0623 | Munster Med INN Annual Survey: 10/22/2024 Please accept the following a facility's credible allegation of correction does not constitut admission of guilt or liability facility and is submitted only response to the regulatory requirement. F623 Notice Requirements E Transfer/Discharge What corrective action(s) will accomplished for those residence of the facility transfer and be policy. How the facility will identify or residents having the potential | e an by the in Before I be dents by the sident copies d hold | | |

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 10/22/2024 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 the resident to be evaluated at the hospital related be affected by the same deficient to her left foot wound becoming progressively practice and what corrective action worse. will be taken: All residents that are transferred or A Nurses' Note, dated 8/8/24 at 10:15 p.m., discharged have the potential to indicated the resident was admitted to the hospital be affected by the same alleged with the diagnosis of gangrene (death of body deficient practice. tissue due to lack of blood flow) to the left foot. What measures will be put into place or what systemic changes The resident returned to the facility on 8/22/24. will be made to ensure that the deficient practice does not recur: There was no indication the State transfer form The Facility Medical Records was mailed to the resident's responsible party. Coordinator was educated to mail (Via USPS) a copy of the notice of During an interview on 10/22/24 at 3:00 p.m., the discharge including the Bed hold Director of Nursing indicated the State transfer policy to the resident's form had not been mailed to the resident's responsible party within 72 hours responsible party. of the resident's transfer and upload proof into the resident's medical record. 2. The record for Resident 16 was reviewed on How the corrective action(s) will be 10/17/24 at 10:26 a.m. Diagnoses included, but monitored to ensure the deficient were not limited to, acute cholecystitis practice will not recur, i.e., what (inflammation of the gallbladder), anxiety, and quality assurance programs will be dementia with behavior disturbance. put into place; Administrator/Designee will audit The Quarterly Minimum Data Set (MDS) weekly to ensure the notice of assessment, dated 9/13/24, indicated the resident transfer discharge including bed was cognitively impaired for daily decision hold policy is provided to residents' responsible parties upon making. transfer/discharge. A Nurses' Note, dated 8/27/24 at 2:30 p.m., The Administrator/designee will indicated the resident was observed in the hall present a summary of the audits screaming. The resident stated her chest hurt and to the Quality Assurance she couldn't breathe, she had also vomited green committee monthly for 6 months. fluid. An order was received to send the resident Thereafter, if determined by the to the emergency room for evaluation. Quality Assurance committee, auditing and monitoring will be Nurses' Notes, dated 8/27/24 at 10:33 p.m., done quarterly and present indicated the resident was admitted to the hospital quarterly at the QA meeting.

| STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA | | (X2) M | (X2) MULTIPLE CONSTRUCTION | | | (X3) DATE SURVEY | |
|--|-----------------------|-----------------------------------|----------------------------|----------|---|------------------|------------|
| AND PLAN | OF CORRECTION | IDENTIFICATION NUMBER | A. BU | JILDING | 00 | COMPL | ETED |
| | | 155131 | B. W | ING | | 10/22/ | /2024 |
| | | | | CTDEET A | ADDRESS, CITY, STATE, ZIP COD | | |
| NAME OF P | ROVIDER OR SUPPLIER | | | | ALUMET AVE | | |
| MUNSTE | R MED-INN | | | | ER, IN 46321 | | |
| | | | _ | | E11, 11 10021 | | T |
| (X4) ID | | STATEMENT OF DEFICIENCIE | | ID | PROVIDER'S PLAN OF CORRECTION | | (X5) |
| PREFIX | | CY MUST BE PRECEDED BY FULL | | PREFIX | (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA | ιΤΕ | COMPLETION |
| TAG | | LSC IDENTIFYING INFORMATION | | TAG | DEFICIENCY) | | DATE |
| | with acute cholecys | titis. | | | Monitoring will be on going. | | |
| | TT1 '1 4 4 | 1, 1, 6, 11, 0/5/24 | | | Date by which systemic | | |
| | The resident returne | ed to the facility on 9/5/24. | | | corrections will be completed: | | |
| | There was no indica | ation the State transfer form | | | 11/8/2024 | | |
| | | esident's responsible party. | | | | | |
| | was maned to the re | esident's responsible party. | | | | | |
| | During an interview | on 10/22/24 at 3:00 p.m., the | | | | | |
| | _ | indicated the State transfer | | | | | |
| | | nailed to the resident's | | | | | |
| | responsible party. | | | | | | |
| | 1 1 | | | | | | |
| 3.1-12(a)(6)(ii) 3.1-12(a)(6)(iii) | | | | | | | |
| | | | | | | | |
| | | | | | | | |
| F 0656 | 483.21(b)(1)(3) | | | | | | |
| SS=D | Develop/Implemer | nt Comprehensive Care Plan | | | | | |
| Bldg. 00 | D 1 1 | | | | l., , ., ., | | 44/00/004 |
| | | riew and interview, the facility | F 0 | 656 | Munster Med-Inn | | 11/08/2024 |
| | developed and in pla | omprehensive care plan was | | | Annual Survey: 10/22/2024 | - 41 | |
| | | f 33 resident care plans | | | Please accept the following as facility's credible allegation of | s trie | |
| | reviewed. (Resident | - | | | compliance. This plan of | | |
| | reviewed. (Resident | . 137) | | | correction does not constitute | an | |
| | Finding includes: | | | | admission of guilt or liability by | | |
| | | | | | facility and is submitted only in | • | |
| | The record for Resid | dent 139 was reviewed on | | | response to the regulatory | | |
| | 10/21/24 at 9:28 a.n | n. Diagnoses included, but | | | requirement. | | |
| | were not limited to, | type 2 diabetes mellitus, | | | F656 Develop/Implement | | |
| | hypertension, and d | epression. | | | Comprehensive Care Plan | | |
| | | | | | What corrective action(s) will b | эе | |
| | - | mum Data Set (MDS) | | | accomplished for those reside | | |
| | | /23/24, indicated the resident | | | found to have been affected b | y the | |
| | | ely impaired and received | | | deficient practice; | | |
| | anti-anxiety and ant | ipsychotic medications. | | | Resident 139's antianxiety | | |
| | A DI COLO | 1 . 14/0/04 . 1 1.1 | | | medication care plan was initia | | |
| | | , dated 4/2/24, indicated the | | | How the facility will identify oth | | |
| | resident was to rece | | | | residents having the potential | | |
| | | (aldol) gel (a hospice | | | be affected by the same defici | | |
| | inedication for agita | ation) to the wrist topically two | | | practice and what corrective a | ction | |

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

2HNN11 Facility ID: 000056

If continuation sheet Page 7 of 49

| STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA | | (X2) MULTIPLE CONSTRUCTION | | ONSTRUCTION | (X3) DATE SURVEY | | | |
|--|----------------------|------------------------------------|-------|---------------------------------------|--|--------------------|------------|--|
| AND PLAN | OF CORRECTION | IDENTIFICATION NUMBER | | JILDING | 00 | COMPL | | |
| | | 155131 | B. WI | NG | | 10/22/ | 2024 | |
| NAME OF F | PROVIDER OR SUPPLIEI | R | - | | ADDRESS, CITY, STATE, ZIP COD | | | |
| MUNSTE | ER MED-INN | | | 7935 CALUMET AVE MUNSTER, IN 46321 | | | | |
| (X4) ID | SUMMARY | STATEMENT OF DEFICIENCIE | | ID | PROVIDER'S PLAN OF CORRECTION | | (X5) | |
| PREFIX | ` | NCY MUST BE PRECEDED BY FULL | | PREFIX | (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA | TE | COMPLETION | |
| TAG | | R LSC IDENTIFYING INFORMATION | | TAG | DEFICIENCY) | | DATE | |
| | times a day for agit | ation and aggressive behavior. | | | will be taken; | | | |
| | TI M I' d' | 1 | | | All residents have the potentia | | | |
| | | Iministration Record (MAR), | | | be affected by the same alleg | ed | | |
| | | cated the resident had received | | | deficient practice. | • | | |
| | the ABH gel medic | ation twice a day. | | | What measures will be put int | | | |
| | There was a lack of | f any current care plan for the | | | place or what systemic chang will be made to ensure that th | | | |
| | | ation, agitation, or aggressive | | | deficient practice does not red | | | |
| | behaviors. | and, agracion, or aggressive | | | Clinical staff were re-educated | | | |
| | | | | | Developing care plans for | | | |
| | During an interview | v on 10/21/24 at 4:41 p.m., the | | | residents related to medicatio | ns | | |
| | _ | g (DON) indicated there was an | | | such anxiolytics. | | | |
| | | cation use care plan and there | | | How the corrective action(s) v | /ill be | | |
| | was an asthma care | plan that mentioned use of | | | monitored to ensure the defici | | | |
| | | as needed. There was no care | | | practice will not recur, i.e., wh | at | | |
| | | d to the anti-anxiety | | | quality assurance programs w | ill be | | |
| | | r agitation or aggressive | | | put into place; | | | |
| | behaviors. | | | | MDS/designee will randomly a | | | |
| | | | | | 5 residents weekly to ensure | | | |
| | 3.1-35(a) | | | | plans are in place. With a spe | | | |
| | | | | | focus on anxiolytic medication | IS. | | |
| | | | | | MDS/designee will present a | | | |
| | | | | | summary of the audits to the | | | |
| | | | | | Quality Assurance committee monthly for 6 months. Therea | ftor | | |
| | | | | | if determined by the Quality | it e i, | | |
| | | | | | Assurance committee, auditin | a | | |
| | | | | | and monitoring will be done | ອ | | |
| | | | | | quarterly and present quarterl | v at | | |
| | | | | | the QA meeting. Monitoring w | - | | |
| | | | | | on going. | | | |
| | | | | | Date by which systemic | | | |
| | | | | | corrections will be completed: | | | |
| | | | | | 11/8/2024 | | | |
| E 0657 | 400 04/5\/0\/:\ /** | \ | | | | | | |
| F 0657 SS=E | 483.21(b)(2)(i)-(iii | • | | | | | | |
| SS-⊑ Bldg. 00 | Care Plan Timing | and Kevision | | | | | | |
| Diag. 00 | Based on observati | on, record review and | F 06 | 557 | Munster Med INN | | 11/08/2024 | |
| | | ity failed to invite and hold care | 1 00 | ו טנ | Annual Survey: 10/22/2024 | | 11/06/2024 | |

| CENTERS FOR MEDICARE & MEDICAID SERVICES | | | | | | OMB NO. 0938-039 | |
|--|--|-------------------------------------|---------|-----------|--|------------------|------------|
| STATEME | NT OF DEFICIENCIES | X1) PROVIDER/SUPPLIER/CLIA | (X2) MU | JLTIPLE C | ONSTRUCTION | (X3) DATE | SURVEY |
| AND PLAN | OF CORRECTION | IDENTIFICATION NUMBER | A. BU | ILDING | 00 | COMPL | LETED |
| | | 155131 | B. WI | NG | | 10/22 | /2024 |
| | | | _ | STREET | ADDRESS, CITY, STATE, ZIP COD | | |
| NAME OF | PROVIDER OR SUPPLIE | R | | | CALUMET AVE | | |
| MUNST | ER MED-INN | | | | TER, IN 46321 | | |
| (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 | TE | COMPLETION |
| TAG | REGULATORY OF | R LSC IDENTIFYING INFORMATION | | TAG | DEFICIENCY) | | DATE |
| | planning conference | es for residents and/or their | | | Please accept the following as | s the | |
| | family members. T | he facility also failed to update a | | | facility's credible allegation of | | |
| | care plan related to | preferences of wearing a | | | compliance. This plan of | | |
| | hospital gown for 6 | of 33 residents whose care | | | correction does not constitute | an | |
| | plans were reviewe | ed. (Residents 1, 9, 129, 141, 72, | | | admission of guilt or liability by | y the | |
| | and 31) | | | | facility and is submitted only in | า | |
| | | | | | response to the regulatory | | |
| | Findings include: | | | | requirement. | | |
| | | | | | F657 Care Plan Timing and | | |
| | 1. During random | observations on 10/15/24 at | | | Revision | | |
| | 2:32 p.m., on 10/16 | 5/24 at 3:57 p.m., and on 10/17/24 | | | What corrective action(s) will be | ое | |
| | at 9:49 a.m., 11:36 | a.m., and 2:08 p.m., Resident 1 | | | accomplished for those reside | | |
| | was observed lying in bed wearing a hospital gown. | | | | found to have been affected b | | |
| | | | | | deficient practice; | • | |
| | | | | | A care conference was sched | uled | |
| | The record for Resi | ident 1 was reviewed on | | | for resident 1, 72, 129, 31, 9, | and | |
| | 10/17/24 at 1:35 p.: | m. Diagnoses included, but were | | | 141. | | |
| | not limited to, mult | tiple sclerosis, neuromuscular | | | Care plans were updated for | | |
| | bladder, vascular de | ementia, major depressive | | | Resident's 1, 72, 129, 31, and | 141 | |
| | disorder, anemia, h | igh blood pressure, anxiety, | | | preferences to wear facility go | | |
| | and pain. | | | | while in bed. | | |
| | | | | | How the facility will identify oth | ner | |
| | The 8/30/24 Quarte | erly Minimum Data Set (MDS) | | | residents having the potential | | |
| | assessment indicate | ed the resident was not | | | be affected by the same defici | ient | |
| | cognitively intact a | nd was severely impaired for | | | practice and what corrective a | | |
| | daily decision mak | ing. The resident was | | | will be taken; | | |
| | dependent on staff | for dressing. | | | All residents have the potentia | al to | |
| | | | | | be affected by this alleged | | |
| | An outdated Care F | Plan, dated 4/27/21, indicated | | | deficient practice. | | |
| | the resident's family | y preferred for the resident to | | | What measures will be put into | 0 | |
| | | n at all times when lying in bed. | | | place or what systemic change | | |
| | | | | | will be made to ensure that the | | |
| | There was no curre | ent care plan indicating the | | | deficient practice does not rec | ur; | |
| | resident wished to l | be dressed in a hospital gown | | | Social Service was re-educate | | |
| | during the day. | | | | on: | | |
| | | | | | Scheduling Quarterly/Annual (| Care | |
| | During an interview | w on 10/18/24 at 10:25 a.m., | | | Conferences. | | |
| | _ | ne had never dressed the | | | Ensuring the resident/Respon | sible | |
| | resident in regular | clothes. | | | Party is invited to attend the | | |

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

2HNN11

Facility ID: 000056

conference.

If continuation sheet

Page 9 of 49

| STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA | | (X2) MULTIPLE CONSTRUCTION (X3) DATE SURV | | | SURVEY | | |
|--|---|---|-------|---------|--|--------|------------|
| AND PLAN | OF CORRECTION | IDENTIFICATION NUMBER | A. BU | UILDING | 00 | COMPL | ETED |
| | | 155131 | B. W | ING | | 10/22/ | 2024 |
| | | | | OTD DET | ADDRESS SITY STATE TIP COD | | |
| NAME OF F | PROVIDER OR SUPPLIEF | 1 | | | ADDRESS, CITY, STATE, ZIP COD | | |
| NALINIOTE | D MED ININ | | | | ALUMET AVE | | |
| MUNSIE | R MED-INN | | | MUNSI | TER, IN 46321 | | |
| (X4) ID | SUMMARY | 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 | REGULATORY OF | LSC IDENTIFYING INFORMATION | | TAG | DEFICIENCY) | 1.2 | DATE |
| | During an interview | on 10/18/24 at 10:35 a.m., the | | | Documenting Conference Dat | e | |
| | Second Floor Unit l | Manager indicated Social | | | and Attendees in the resident' | | |
| | Service was respons | sible for updating all of the | | | medical record. | | |
| | transitional care pla | ns regarding the residents | | | How the corrective action(s) w | ill be | |
| | wearing hospital go | wns into the new point click | | | monitored to ensure the defici | | |
| | care computer syste | | | | practice will not recur, i.e., who | | |
| | | | | | quality assurance programs w | | |
| | During an interview | on 10/18/24 at 10:37 a.m., the | | | put into place; | | |
| | 1 | ctor indicated she had not had | | | Administrator/Designee will au | ıdit | |
| | time to transfer the | resident's care plan into point | | | care conferences scheduled for | | |
| | click care. | | | | the week to ensure the | | |
| | | | | | resident/responsible party was | 3 | |
| | | | | | invited to attend and the | | |
| | 2. During a telepho | one interview on 10/16/24 at | | | conference is documented in t | :he | |
| | 2:28 p.m., Resident | 9's son indicated he had | | | resident's medical record. | | |
| | received an invitation | on to maybe 1 or 2 care | | | The Administrator/designee w | ill | |
| | conferences, but he | was working at the time the | | | present a summary of the aud | its | |
| | facility had them so | heduled and no one from the | | | to the Quality Assurance | | |
| | facility had ever cal | led him to see if it could be | | | committee monthly for 6 mont | hs. | |
| | rescheduled. | | | | Thereafter, if determined by th | ie | |
| | | | | | Quality Assurance committee, | | |
| | The record for Resi | dent 9 was reviewed on | | | auditing and monitoring will be | , | |
| | 10/17/24 at 4:00 p.r | n. Diagnoses included but were | | | done quarterly and present | | |
| | not limited to, heart | disease, dementia with | | | quarterly at the QA meeting. | | |
| | | c disorder with delusions, | | | Monitoring will be on going. | | |
| | | sorder, chronic pain, high | | | Date by which systemic | | |
| | blood pressure, and | adult failure to thrive. | | | corrections will be completed: | | |
| | | | | | 11/8/2024 | | |
| | 1 | rly Minimum Data Set (MDS) | | | | | |
| | | d the resident was severely | | | | | |
| | _ | on making and was dependent | | | | | |
| | on staff for activitie | es of daily living. | | | | | |
| | | | | | | | |
| | There was no documentation indicating the | | | | | | |
| | resident had a care | planning conference in the last | | | | | |
| | year. | | | | | | |
| | | | | | | | |
| | _ | on 10/18/24 at 11:25 a.m., the | | | | | |
| | | Manager indicated the office | | | | | |
| | downstairs sent out | the invitations for the care | | | | | |

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

2HNN11 Facility ID: 000056

If continuation sheet Page 10 of 49

| STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA | | X1) PROVIDER/SUPPLIER/CLIA | (X2) MULTIPLE CONSTRUCTION | | | (X3) DATE SURVEY | | |
|--|--|--|----------------------------|----------|---|------------------|------------|--|
| AND PLAN | OF CORRECTION | IDENTIFICATION NUMBER | A. BU | JILDING | 00 | COMPL | COMPLETED | |
| | | 155131 | B. W | ING | | 10/22 | /2024 | |
|),,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,, | NOVEMBER OF STREET | | | STREET A | ADDRESS, CITY, STATE, ZIP COD | | | |
| NAME OF F | PROVIDER OR SUPPLIER | ₹ | | | ALUMET AVE | | | |
| MUNSTE | R MED-INN | | | MUNST | FER, IN 46321 | | | |
| (X4) ID | SUMMARY STATEMENT OF DEFICIENCIE | | | ID | PROVIDER'S PLAN OF CORRECTION | | (X5) | |
| PREFIX | | ICY MUST BE PRECEDED BY FULL | | PREFIX | (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY) | TE | COMPLETION | |
| TAG | | R LSC IDENTIFYING INFORMATION e families. The unit manager | | TAG | DET TO LEAVE ! | | DATE | |
| | ^ · | mail when the residents were | | | | | | |
| | | cated care plan meetings for | | | | | | |
| | | ot held when the family didn't | | | | | | |
| | show up. | | | | | | | |
| | During an interviev | v on 10/18/24 on 11:30 a.m., the | | | | | | |
| | _ | ector indicated there had been | | | | | | |
| | • | ngs for the resident because the | | | | | | |
| | 1 | v up. She was unaware a care | | | | | | |
| | | d to be held even if the family | | | | | | |
| | | he resident was cognitively | | | | | | |
| | impaired. 3. During an interview on 10/15/24 at 11:26 a.m., | | | | | | | |
| | | | | | | | | |
| | | ated he had not had a care | | | | | | |
| | | e since he had been at the | | | | | | |
| | facility. | | | | | | | |
| | | ident 129 was reviewed on | | | | | | |
| | _ | m. The resident was admitted to | | | | | | |
| | 1 | /24. Diagnoses included, but | | | | | | |
| | | , COPD (chronic obstructive , chronic respiratory failure, | | | | | | |
| | | disease, anxiety, palliative care, | | | | | | |
| | | gen, and chronic pain. | | | | | | |
| | TI 0/1/04 A 1 | ' M' ' D (C (AFDC) | | | | | | |
| | | ion Minimum Data Set (MDS) ed the resident was cognitively | | | | | | |
| | intact for daily deci | | | | | | | |
| | muce for during deer | and maning. | | | | | | |
| | | mentation the resident had a | | | | | | |
| | | thin the first 30 days of | | | | | | |
| | admission. | | | | | | | |
| | During an interview on 10/18/24 at 11:30 a.m., the | | | | | | | |
| | | al Service Director indicated the | | | | | | |
| | | d a care plan meeting since | | | | | | |
| | admission. | | 1 | | | | 1 | |

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

2HNN11 Facility ID: 000056

If continuation sheet Page 11 of 49

| STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA | | (X2) MULTIPLE CO | ONSTRUCTION | (X3) DATE SURVEY | |
|--|----------------------------|----------------------------------|-------------|--|------------|
| AND PLAN | OF CORRECTION | IDENTIFICATION NUMBER | A. BUILDING | 00 | COMPLETED |
| | | 155131 | B. WING | | 10/22/2024 |
| | | | CED FIRE | ADDRESS CITY STATE TIP COD | |
| NAME OF F | ROVIDER OR SUPPLIER | 8 | | ADDRESS, CITY, STATE, ZIP COD | |
| MUNICTE | R MED-INN | | | ALUMET AVE FER, IN 46321 | |
| MONSIE | K MED-IMM | | MONS | EK, IN 40321 | |
| (X4) ID | SUMMARY | 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 | COMPLETION |
| TAG | REGULATORY OF | R LSC IDENTIFYING INFORMATION | TAG | DEFICIENCY) | DATE |
| | | | | | |
| | | | | | |
| | | riew on 10/15/24 at 2:51 p.m., | | | |
| | | ated she had not had a care | | | |
| | planning conference | e since she had been at the | | | |
| | facility. | | | | |
| | | | | | |
| | | dent 141 was reviewed on | | | |
| | - | m. The resident was admitted | | | |
| | | the diagnoses of peripheral | | | |
| | | y, type 2 diabetes, morbid | | | |
| | | l pressure, osteoarthritis, and | | | |
| | major depressive disorder. | | | | |
| | TI 0/25/24 O | 1 Mili Die Garando | | | |
| | | rly Minimum Data Set (MDS) | | | |
| | | d the resident was cognitively | | | |
| | intact for daily deci | sion making. | | | |
| | There was no deau | mentation the resident had a | | | |
| | | erence within the first 30 days | | | |
| | | ter the first Quarterly MDS | | | |
| | assessment. | ter the first Quarterly MD3 | | | |
| | assessment. | | | | |
| | During an interview | on 10/21/24 on 12:15 p.m., the | | | |
| | _ | ctor indicated there had been | | | |
| | no care plan meetin | | | | |
| | no ouro prum mooun | go for the resident | | | |
| | During an interview | v on 10/22/24 at 8:30 a.m., | | | |
| | - | istant 1 indicated she received | | | |
| | a list of residents w | ho needed care plan meetings | | | |
| | | S office around the third week | | | |
| | _ | hen prepared the letters for | | | |
| | | s were scheduled and sent | | | |
| | _ | ilies or gave them to the | | | |
| | | e their own responsible party. | | | |
| | - | s responsible for inviting the | | | |
| | | etings. 5. The record for | | | |
| | | viewed on 10/18/24 at 9:59 a.m. | | | |
| | Diagnoses included | , but were not limited to, heart | | | |
| | - | iabetes, anemia, and high blood | | | |

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

2HNN11 Facility ID: 000056

If continuation sheet

Page 12 of 49

| AND PLAN OF CORRECTION DENTIFICATION NUMBER 155131 B. WING 0 D. COMPLETED 10/22/2024 NAME OF PROVIDER OR SUPPLIER WINSTER MED-INN CA) ID SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRICEDED BY PULL TAG) PREFIX (EACH DEFICIENCY MUST BE PRICEDED BY PULL TAG) PREFIX (FACILITY MINIMUM DATA SET (MDS) assessment, dated 8/28/24, indicated the resident was moderately impaired for daily decision making. A Social Service Progress Note, dated 1/15/24 at 2.29 p.m., indicated the staff member met with the resident to discuss his quarterly assessment. There was no documentation about inviting the resident for a supportive visit. There was no documentation about inviting the resident for a supportive visit. There was no documentation about inviting the resident for a supportive visit. There was no documentation about inviting the resident to his care conference. During an interview on 10/18/24 at 11:25 a.m., the Second Floor Unit Manager indicated the office downstairs sent out the invitations for the care plan meetings to the families and she got an email on when they were scheduled. During an interview on 10/18/24 at 11:30 a.m., the Social Service Director (SSD) indicated she was unaware a care plan meetings to the families and the resident was cognitively impaired. During an interview on 10/18/24 at 2:33 p.m., the Director of Nursing (DON) indicated the care plan by the desired of the care plan by the process of the process of the care plan by the process of | STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA | | (X2) MULTIPLE CONSTRUCTION (X3) DATE SUR | | | SURVEY | | |
|--|--|--|--|------|-------|-----------------------------------|-------|-------|
| NAME OF PROVIDER OR SUPPLIER MUNSTER MED-INN (X4) ID SUMMARY STATEMENT OF DEFICIENCIE PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG PRESSURE. The Quarterly Minimum Data Set (MDS) assessment, dated 8/28/24, indicated the resident was moderately impaired for daily decision making. A Social Service Progress Note, dated 1/15/24 at 2:29 p.m., indicated the staff member met with the resident to discuss his quarterly assessment. There was no documentation about inviting the resident to his care conference. A Social Service Progress Note, dated 2/13/24 at 11:07 a.m., indicated the staff member met with the resident for assupportive vist. There was no documentation about inviting the resident for as upportive vist. There was no documentation about inviting the resident for assupportive vist. There was no documentation about inviting the resident for assupportive vist. There was no documentation about inviting the resident for assupportive vist. There was no documentation about inviting the resident for assupportive vist. There was no documentation about inviting the resident for assupportive vist. There was no documentation about inviting the resident for assupportive vist. There was no documentation about inviting the resident for assupportive vist. There was no documentation about inviting the resident for assupportive vist. There was no documentation about inviting the resident to his care conference. During an interview on 10/18/24 at 11:30 a.m., the Social Service Director (SSD) indicated she was unaware a care plan meeting needed to be held even if the family did not attend, and the resident was cognitively impaired. During an interview on 10/18/24 at 2:33 p.m., the | AND PLAN (| OF CORRECTION | IDENTIFICATION NUMBER | | | | | LETED |
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| downstairs sent out the invitations for the care plan meetings to the families and she got an email on when they were scheduled. During an interview on 10/18/24 at 11:30 a.m., the Social Service Director (SSD) indicated she was unaware a care plan meeting needed to be held even if the family did not attend, and the resident was cognitively impaired. During an interview on 10/18/24 at 2:33 p.m., the | | _ | | | | | | |
| on when they were scheduled. During an interview on 10/18/24 at 11:30 a.m., the Social Service Director (SSD) indicated she was unaware a care plan meeting needed to be held even if the family did not attend, and the resident was cognitively impaired. During an interview on 10/18/24 at 2:33 p.m., the | | | _ | | | | | |
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| Social Service Director (SSD) indicated she was unaware a care plan meeting needed to be held even if the family did not attend, and the resident was cognitively impaired. During an interview on 10/18/24 at 2:33 p.m., the | | on when they were | scheduled. | | | | | |
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| unaware a care plan meeting needed to be held even if the family did not attend, and the resident was cognitively impaired. During an interview on 10/18/24 at 2:33 p.m., the | | _ | | | | | | |
| was cognitively impaired. During an interview on 10/18/24 at 2:33 p.m., the | | | | | | | | |
| During an interview on 10/18/24 at 2:33 p.m., the | | even if the family d | id not attend, and the resident | | | | | |
| | | was cognitively imp | paired. | | | | | |
| | | During an interview | y on 10/18/24 at 2:33 n m the | | | | | |
| | | _ | _ | | | | | |
| meetings should have been documented once | | | | | | | | |
| they were completed, and any invites should have | | _ | | | | | | |
| been followed up on. | | been followed up or | n. | | | | | |
| During an interview on 10/21/24 at 11:47 a.m. the | | During an interview on 10/21/24 at 11.47 and the | | | | | | |
| SSD indicated the resident did not have a care | | During an interview on 10/21/24 at 11:47 a.m., the | | | | | | |
| plan meeting this year because he just received a | | | | | | | | |

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

2HNN11 Facility ID: 000056

If continuation sheet Page 13 of 49

| AND PLAN OF CORRECTION IDENTIFICATION NUMBER | | (X2) MULTIPLE CO A. BUILDING B. WING | onstruction <u>00</u> | (X3) DATE SURVEY COMPLETED 10/22/2024 | |
|--|--|--|--------------------------|--|----------------------|
| | F PROVIDER OR SUPPLIEI FER MED-INN | R | 7935 C | ADDRESS, CITY, STATE, ZIP COD CALUMET AVE TER, IN 46321 | |
| (X4) ID PREFIX TAG | (EACH DEFICIEN REGULATORY O | STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION | ID PREFIX TAG | PROVIDERS PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY) | (X5) COMPLETION DATE |
| | guardian. 6. The record for R 10/18/24 at 1:26 p. were not limited to heart failure, dysph hypertension (high iron), and diabetes. The Quarterly Min assessment, dated 8 was cognitively int A Social Service P 1:17 p.m., indicate resident to discuss There was no docu resident to her care There was no docu invited to attend he During an interview Second Floor Unit downstairs sent out plan meetings to th email on when they During an interview Director of Nursing meetings should ha they were complete been followed up of | desident 31 was reviewed on m. Diagnoses included, but places, kidney disease, paraplegia, lagia (difficulty swallowing), blood pressure), anemia (low dimum Data Set (MDS) 8/16/24, indicated the resident act for daily decision making. Togress Note, dated 1/9/24 at difficulty | | | |

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

2HNN11 Facility ID: 000056

If continuation sheet Page 14 of 49

| STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA | | (X2) M | | | | (X3) DATE SURVEY | | |
|--|----------------------|--|-------|-----------------------|---|-------------------|------------|--|
| AND PLAN | OF CORRECTION | IDENTIFICATION NUMBER | A. BU | A. BUILDING <u>00</u> | | COMPL | COMPLETED | |
| | | 155131 | B. W | ING | | 10/22/ | /2024 | |
| | | | | STREET | ADDRESS, CITY, STATE, ZIP COD | <u> </u> | | |
| NAME OF P | PROVIDER OR SUPPLIER | L | | | ALUMET AVE | | | |
| MUNSTE | R MED-INN | | | | ΓER, IN 46321 | | | |
| (X4) ID | SUMMARY | STATEMENT OF DEFICIENCIE | 1 | ID | | | (X5) | |
| PREFIX | | CY MUST BE PRECEDED BY FULL | | PREFIX | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA | | COMPLETION | |
| TAG | ` | LSC IDENTIFYING INFORMATION | | TAG | CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY) | TE | DATE | |
| F 0677 | | | | | | | | |
| SS=E | 483.24(a)(2) | ed for Dependent Residents | | | | | | |
| Bldg. 00 | ADL Care Provide | d for Dependent Residents | | | | | | |
| Diag. 00 | Based on observation | on, record review, and | F 0 | 677 | Munster Med INN | | 11/08/2024 | |
| | | ty failed to ensure dependent | 1 0 | 077 | Annual Survey: 10/22/2024 | | 11/06/2024 | |
| | | ADL (Activities of Daily | | | Please accept the following as | : the | | |
| | | to long and dirty fingernails | | | facility's credible allegation of | , 1110 | | |
| | | of 11 residents reviewed for | | | compliance. This plan of | | | |
| | ADL's. (Residents 1 | | | | correction does not constitute | an | | |
| | | , | | | admission of guilt or liability by | | | |
| | Findings include: | | | | facility and is submitted only in | | | |
| | C | | | | response to the regulatory | | | |
| | 1. During random of | bservations on 10/15/24 at 2:32 | | | requirement. | | | |
| | p.m., on 10/16/24 at | t 3:57 p.m., on 10/17/24 at 9:49 | | | F677 ADL Care Provided for | | | |
| | a.m., 11:36 a.m. and | d 2:08 p.m., and on 10/18/24 at | | | Dependent Residents | | | |
| | 9:10 a.m., Resident | 1 was observed with long | | | What corrective action(s) will be | эе | | |
| | fingernails on both | hands. | | | accomplished for those reside | nts | | |
| | | | | | found to have been affected b | y the | | |
| | The record for Resi | dent 1 was reviewed on | | | deficient practice; | | | |
| | - | n. Diagnoses included, but were | | | R116, R1, R6, and R129 Nails | } | | |
| | | iple sclerosis, neuromuscular | | | were cleaned and trimmed | | | |
| | | ementia, major depressive | | | immediately | | | |
| | | gh blood pressure, anxiety, | | | R6 and R129 were immediate | - | | |
| | and pain. | | | | assisted with trimming facial h | | | |
| | | | | | How the facility will identify oth | | | |
| | | rly Minimum Data Set (MDS) | | | residents having the potential | | | |
| | | d the resident was not | | | be affected by the same defici | | | |
| | | nd was severely impaired for | | | practice and what corrective a | ction | | |
| | | ng. The resident was | | | will be taken; | | | |
| | personal and oral hy | for dressing, toileting, eating, | | | All residents requiring assistar | | | |
| | personal and oral ny | ygiene. | | | with ADL Care have the poten | | | |
| | The Care Plan date | d 3/12/24, indicated the | | | to be affected by the same allowed deficient practice. | ∍g c u | | |
| | resident had an AD | | | | What measures will be put into | 0 | | |
| | 1051dein nad an AD | 2 son oure deficit. | | | place or what systemic change | | | |
| | The CNA task secti | on under bathing, indicated | | | will be made to ensure that the | | | |
| | | led to the resident on | | | deficient practice does not rec | | | |
| | 10/13-10/17/24. | The state of the s | | | Nursing Staff will be educated | | | |
| | | | | | · Grooming residents' facial ha | | | |
| | During an interview | on 10/18/24 at 10:25 a.m., | | | cleaning/trimming nails, and | , | | |
| l l | ı | · · · · · · · · · · · · · · · · · · · | 1 | |] | | I | |

| STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA | | (X2) MULTIPLE CONSTRUCTION (X3) DAT | | | (X3) DATE | SURVEY | |
|--|---|-------------------------------------|---------------------------------|--------|---|--------|------------|
| AND PLAN | OF CORRECTION | IDENTIFICATION NUMBER | A. BUILDING <u>00</u> COMPLETED | | | ETED | |
| | | 155131 | B. WING 10/22/2024 | | | 2024 | |
| | | | | CENTER | ADDRESS OF A STATE OF COR | | |
| NAME OF I | PROVIDER OR SUPPLIEF | 8 | | | ADDRESS, CITY, STATE, ZIP COD | | |
| MUNIOTE | D MED INN | | | | ALUMET AVE | | |
| MUNSTE | R MED-INN | | | MUNSI | TER, IN 46321 | | |
| (X4) ID | SUMMARY | 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 DEFICIENCY) | TE | COMPLETION |
| TAG | REGULATORY OF | R LSC IDENTIFYING INFORMATION | | TAG | DEFICIENCY) | i.L | DATE |
| | CNA 2 indicated sh | ne had not cut the resident's | | | assistance with ADL care per | plan | |
| | fingernails. | | | | of care. | | |
| | | | | | How the corrective action(s) w | ill be | |
| | During an interview | v on 10/18/24 at 10:35 a.m., the | | | monitored to ensure the deficient | | |
| | Second Floor Unit Manager was not aware the resident's fingernails were that long. | | | | practice will not recur, i.e., who | at | |
| | | | | | quality assurance programs w | ill be | |
| | | | | | put into place; | | |
| | 2. During an interview on 10/16/24 at 11:30 a.m., Resident 6 indicated her fingernails were very | | | | Facility Angels will Aduit 10 | | |
| | | | | | residents 2 times weekly to | | |
| | | | | | ensure that grooming is compl | eted | |
| | long and in need of trimming. The nails on both | | | | with ADL care with a special for | ocus | |
| | hands were also dirty. The resident had a | | | | on nailcare and facial hair. | | |
| | moderate amount of facial hair on her chin, and | | | | Director of Nursing/designee v | vill | |
| | wanted that cut as well. | | | | present a summary of the aud | its | |
| | | | | | to the Quality Assurance | | |
| | During random obs | ervations on 10/17/24 at 9:50 | | | committee monthly for 6 month | ns. | |
| | | nd 2:30 p.m., the resident's | | | Thereafter, if determined by th | е | |
| | _ | ll long and dirty and her facial | | | Quality Assurance committee, | | |
| | hair remained to he | r chin and neck areas. | | | auditing and monitoring will be | : | |
| | | | | | done quarterly and present | | |
| | | dent 6 was reviewed on | | | quarterly at the QA meeting. | | |
| | | .m. Diagnoses included, but | | | Monitoring will be on going. | | |
| | | atrial fibrillation, heart failure, | | | Date by which systemic | | |
| | | sorder, reduced mobility, | | | corrections will be completed: | | |
| | | e late onset, dementia with | | | 11/8/2024 | | |
| | _ | od pressure, and adult failure | | | | | |
| | to thrive. | | | | | | |
| | | | | | | | |
| | ` ` | mum Data Set (MDS) | | | | | |
| | | 0/2/24, indicated the resident | | | | | |
| | | act for daily decision making. | | | | | |
| | | d substantial to maximal | | | | | |
| | assistance with pers | sonal hygiene. | | | | | |
| | A.C. Di | 1 0/20/24 : 1: 4 1:1 | | | | | |
| | | d on 8/20/24, indicated the | | | | | |
| | resident had an AD | L self care deficit. | | | | | |
| | TEL COLLA 1 | 1 1 42 2 2 2 | | | | | |
| | | on under bathing, indicated | | | | | |
| | | completed on 9/18, 9/19, 9/24, | | | | | |
| | 9/25, 9/27-9/29, 10/ | /1-10/9, 10/14 and 10/16/24. | | | | | |

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

2HNN11 Facility ID: 000056

If continuation sheet Page 16 of 49

| | | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155131 | (X2) MULTIPLE CO A. BUILDING B. WING | ONSTRUCTION 00 | (X3) DATE SURVEY COMPLETED 10/22/2024 | |
|--------------------------|--|---|--|--|---------------------------------------|--|
| | PROVIDER OR SUPPLIEF | | 7935 C | ADDRESS, CITY, STATE, ZIP COD ALUMET AVE FER, 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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI. DEFICIENCY) | (X5) COMPLETION DATE | |
| IAU | There was no docur resident had been slowers and interview 2 indicated the resident had cativity department once a week. She was were long and dirty her chin. During an interview Second Floor Unit I department was not cleaning the resident 3. During an interview Resident 129 indicating fingernails that need indicated he wanted shaven. During random obs p.m., on 10/17/24 at p.m., and on 10/18/observed with long a large amount of fameck area. The record for Resi 10/17/24 at 2:15 p.1 the facility on 8/26/were not limited to, pulmonary disease) heart failure, heart of dependence on oxygeners. | mentation indicating the haved. If you on 10/18/24 at 10:20 a.m. CNA dent did not refuse care and then provided nail care for her was unaware the resident's nails and that she had facial hair on If you on 10/18/24 at 11:00 a.m., the Manager indicated the activity responsible for cutting and this nails. It wo on 10/15/24 at 11:29 a.m., the de had long and dirty did to be cut. He also did a shave and liked to be clean If you have a did to the clean at the resident was and dirty fingernails as well as acial hair on his cheeks and If you have a did to be clean at the resident was and dirty fingernails as well as acial hair on his cheeks and If you have a did the resident was admitted to (24. Diagnoses included, but COPD (chronic obstructive core, chronic respiratory failure, disease, anxiety, palliative care, gen, and chronic pain. | IAG | | DATE | |
| ı | The 9/1/24 Admiss | ion Minimum Data Set (MDS) | | | | |

FORM CMS-2567(02-99) Previous Versions Obsolete

assessment indicated the resident was cognitively

Event ID:

2HNN11

Facility ID: 000056

If continuation sheet

Page 17 of 49

| STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA | | (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY | | | |
|--|--|--|--------------------------|---|------------|
| AND PLAN | OF CORRECTION | IDENTIFICATION NUMBER | A. BUILDING 00 COMPLETED | | |
| | | 155131 | B. WING | | 10/22/2024 |
| NAME OF F | PROVIDER OR SUPPLIER | | | ADDRESS, CITY, STATE, ZIP COD | |
| MUNSTE | ER MED-INN | | | CALUMET AVE TER, 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 BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY) | |
| TAG | | S LSC IDENTIFYING INFORMATION sion making. The resident | TAG | DEFICIENCY | DATE |
| | 1 | maximal assist for bathing and | | | |
| | personal hygiene. | maximar assist for outling and | | | |
| | A Care Plan, dated | 8/27/24, indicated the resident | | | |
| | had an ADL self ca | | | | |
| | | on under bathing, indicated | | | |
| | _ | ded on 9/19, 9/23, 9/25, 9/26, | | | |
| | 9/27, 9/28, 9/30-10/ | /4, and 10/16/24. | | | |
| | | ed a complete bed bath on | | | |
| | | /1-10/4, 10/6-10/9, 10/12-10/14, | | | |
| | and 10/16-10/17/24, however, there was no documentation indicating the resident had been | | | | |
| | shaved. | eating the resident had been | | | |
| | | | | | |
| | _ | on 10/21/24 at 11:55 p.m., the | | | |
| | | Manager indicated nails were | | | |
| | | facial hair was to be removed as 5/24 at 2:39 p.m., Resident 116 | | | |
| | | whiskers on her chin and long | | | |
| | | k dirty debris underneath the | | | |
| | nails. | | | | |
| | On 10/17/24 at 10:0 | 3 a.m., the resident had | | | |
| | whiskers on her chi | n and her nails were long and | | | |
| | dirty. | | | | |
| | | 4 a.m. and 11:33 a.m., the | | | |
| | | red in bed and her fingernails | | | |
| | _ | dirty with dark debris beneath | | | |
| | the nails. | | | | |
| | | 53 a.m., the resident was | | | |
| | | her fingernails were still long | | | |
| | and dirty with dark | debris under her nails. | | | |
| | The record for Resi | dent 116 was reviewed on | | | |
| | | m. Diagnoses included, but | | | |

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

2HNN11 Facility ID: 000056

If continuation sheet Page 18 of 49

| CENTERS FOR MEDICARE & MEDICAID SERVICES | | | | | OMB NO. 0938-039 | |
|--|--|---|-------------------|--|------------------|--|
| STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155131 | | (X2) MULTIPLE C A. BUILDING B. WING | onstruction 00 | (X3) DATE SURVEY COMPLETED 10/22/2024 | | |
| | PROVIDER OR SUPPLIEF | ? | 7935 C | ADDRESS, CITY, STATE, ZIP COD CALUMET AVE TER, IN 46321 | | |
| (X4) ID PREFIX | (EACH DEFICIEN | STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL | ID PREFIX | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPR DEFICIENCY) | RIATE CONTINUE | |
| TAG | were not limited to, cholesterol), hypert | hyperlipidemia (high ension (high blood pressure), ty swallowing), and hearing | TAG | DEFICIENCY | DATE | |
| | assessment, dated 8 was severely impai The resident had ra both sides of her lo | imum Data Set (MDS) 6/26/24, indicated the resident red for daily decision making. inge of motion impairment on wer extremities and was with all activities of daily | | | | |
| | | 6/19/24, indicated the resident on problem related to deafness. | | | | |
| | had severe cognitiv | 6/19/24, indicated the resident e impairment. Interventions anticipate care with all ADL's. | | | | |
| | Nail care was docu 10/16, 10/19, and 1 | mented as completed on 10/14, 0/20/2024. | | | | |
| | Director of Nursing | y on 10/18/24 at 4:34 p.m., the g (DON) indicated the resident's uld have been groomed. | | | | |
| | | v on 10/21/24 at 11:56 a.m., LPN aight they cut and cleaned the bath days. | | | | |
| | 3.1-38(a)(3)(D) 3.1-38(a)(3)(E) | | | | | |
| F 0684 SS=D Bldg. 00 | 483.25 Quality of Care | | | | | |
| - | | on, record review, and ty failed to ensure areas of | F 0684 | Munster Med-Inn Annual Survey: 10/22/2024 | 11/08/2024 | |

FORM CMS-2567(02-99) Previous Versions Obsolete

bruising and scabbing were assessed and

Event ID:

2HNN11

Facility ID: 000056

If continuation sheet

Please accept the following as the

Page 19 of 49

| STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA | | X1) PROVIDER/SUPPLIER/CLIA | (X2) MULTIPLE CONSTRUCTION | | (X3) DATE SURVEY | | |
|--|--|----------------------------------|----------------------------|---------|--|----------|------------|
| AND PLAN | OF CORRECTION | IDENTIFICATION NUMBER | A. BU | JILDING | 00 | COMPL | ETED |
| | | 155131 | B. W | ING | | 10/22/ | /2024 |
| | | | | STREET | ADDRESS, CITY, STATE, ZIP COD | <u> </u> | |
| NAME OF F | PROVIDER OR SUPPLIEF | ₹ | | | ALUMET AVE | | |
| MUNISTE | R MED-INN | | | | TER, IN 46321 | | |
| IVIUINOTE | | | | IVIONST | LIN, IIN 4002 I | | |
| (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 | TE | COMPLETION |
| TAG | REGULATORY OF | R LSC IDENTIFYING INFORMATION | | TAG | DEFICIENCY) | | DATE |
| | monitored, and treatments were in place for | | | | facility's credible allegation of | | |
| | | njuries for 3 of 3 residents | | | compliance. This plan of | | |
| | reviewed for skin conditions non-pressure related. (Residents 56, 79, and 6) | | | | correction does not constitute | an | |
| | | | | | admission of guilt or liability by | / the | |
| | | | | | facility and is submitted only ir | า | |
| | Findings include: | | | | response to the regulatory | | |
| | | | | | requirement. | | |
| | 1. On 10/15/24 at 11:07 a.m., Resident 56 was | | | | F684 Quality of Care | | |
| | observed in his room in bed. He had an area of | | | | What corrective action(s) will t | ре | |
| | reddish/purple disco | oloration to the top of his left | | | accomplished for those reside | nts | |
| | hand. | | | | found to have been affected b | y the | |
| | | | | | deficient practice; | | |
| | The record for Resident 56 was reviewed on | | | | Resident's 79 treatment was | | |
| | 10/18/24 at 10:30 a | .m. Diagnoses included, but | | | re-applied and care plan for | | |
| | were not limited to, | Alzheimer's disease, anemia, | | | resident removing treatment ir | า | |
| | and type 2 diabetes. | | | | place. R56, and 6's bruises w | ere | |
| | | | | | assessed. MD was notified. N | ew | |
| | | mum Data Set (MDS) | | | orders were obtained to monit | or | |
| | | /20/24, indicated the resident | | | bruising. | | |
| | | paired for daily decision making | | | How the facility will identify oth | ner | |
| | _ | ntial to maximum assistance | | | residents having the potential | to | |
| | with rolling left and | I right and for chair to bed | | | be affected by the same defici | ent | |
| | transfers. | | | | practice and what corrective a | ction | |
| | | | | | will be taken; | | |
| | | t have a current care plan | | | All residents have the potentia | | |
| | related to the bruisi | ng to his left hand. | | | be affected by the same allege | ed | |
| | | | | | deficient practice. | | |
| | · · | servation form, dated 10/17/24, | | | What measures will be put into | | |
| | | nt's skin was intact and there | | | place or what systemic change | | |
| | was no documentat | ion related to bruising. | | | will be made to ensure that the | | |
| | | | | | deficient practice does not rec | ur; | |
| | | ion on 10/18/24 at 11:17 a.m., | | | Nurses were re-educated on: | | |
| | | tor of Nursing confirmed the | | | · Addressing and assessing | | |
| | | top of the resident's left hand. | | | changes in skin condition such | n as | |
| | | uld get an order to monitor the | | | bruises, obtaining orders for | | |
| | bruising. | | | | treatment, and implementation | n of | |
| | | | | | treatment. | | |
| | 1 | r, dated 10/18/24, indicated the | | | Assistive clinical staff were | | |
| | | nt's left hand was to be | | | educated on: | | |
| | monitored every sh | ift until resolved. | 1 | | · Notifying the nurse of any | | |

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

2HNN11

Facility ID: 000056

If continuation sheet

Page 20 of 49

| STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA | | (X2) MULTIPLE CONSTRUCTION | | | (X3) DATE SURVEY | | |
|--|---|-------------------------------------|-----------------------|---------|--|---------------------------|------------|
| AND PLAN | OF CORRECTION | IDENTIFICATION NUMBER | A. BUILDING <u>00</u> | | COMPLETED | | |
| | | 155131 | B. WING | | | 10/22/ | /2024 |
| | | | | CTD FET | ADDRESS CITY STATE ZID COD | | |
| NAME OF P | ROVIDER OR SUPPLIER | 1 | | | ADDRESS, CITY, STATE, ZIP COD | | |
| MUNICITE | D MED INN | | | | ALUMET AVE | | |
| MUNSIE | R MED-INN | | | MUNSI | ER, IN 46321 | | |
| (X4) ID | SUMMARY | STATEMENT OF DEFICIENCIE | | ID | PROVIDER'S PLAN OF CORRECTION | S PLAN OF CORRECTION (X5) | |
| PREFIX | (EACH DEFICIEN | CY MUST BE PRECEDED BY FULL | | PREFIX | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' | TE | COMPLETION |
| TAG | REGULATORY OR | LSC IDENTIFYING INFORMATION | | TAG | DEFICIENCY) | . = | DATE |
| | | | | | change in residents' skin | | |
| | | | | | conditions. | | |
| | 2. On 10/15/24 at 10:40 a.m., 11:07 a.m. and 3:14 | | | | How the corrective action(s) w | ill be | |
| | | vas observed in his room in bed. | | | monitored to ensure the deficient | | |
| | The resident had a l | arge open area to his left | | | practice will not recur, i.e., wha | | |
| | upper jaw that was: | | | | quality assurance programs w | | |
| | | | | | put into place; | | |
| | On 10/16/24 at 11:3 | 34 a.m., 12:12 p.m., and 3:55 p.m., | | | Facility Angels/designee will | | |
| | | ated in his wheelchair | | | complete observation rounds | on | |
| | | around the unit. The open area | | | 10 residents 3 times per week | | |
| | to his left upper jaw | _ | | | ensure areas of bruising are | | |
| | 11 3 | | | | reported to the nurse. | | |
| | The record for Resident 79 was reviewed on | | | | Director of Nursing/designee v | vill | |
| | 10/17/24 at 10:55 a.m. Diagnoses included, but | | | | present a summary of the aud | | |
| | | dementia with behavior | | | to the Quality Assurance | | |
| | | mer's disease with late onset, | | | committee monthly for 6 month | าร | |
| | anxiety, and major | | | | Thereafter, if determined by th | | |
| | J, J | 1 | | | Quality Assurance committee, | _ | |
| | The 8/17/24 Ouarte | rly Minimum Data Set (MDS) | | | auditing and monitoring will be | | |
| | · · | d the resident was cognitively | | | done quarterly and present | | |
| | | lecision making. The resident | | | quarterly at the QA meeting. | | |
| | - | g an open lesion other than | | | Monitoring will be on going. | | |
| | ulcers, rashes, or cu | | | | Date by which systemic | | |
| | , , | | | | corrections will be completed: | | |
| | A Care Plan, dated | 4/26/24, indicated the resident | | | 11/8/2024 | | |
| | | (history of cancer) to the left | | | , 6, 262 : | | |
| | | included, but were not limited | | | | | |
| | - | rotocols for treatment of injury. | | | | | |
| | , , , , , | 3 3 | | | | | |
| | A Physician's Order | r, dated 9/12/24, indicated the | | | | | |
| | = | vound was to be cleansed with | | | | | |
| | | r wound cleanser and apply | | | | | |
| | | a medication to treat skin | | | | | |
| | · · | d and cover with a dry | | | | | |
| | · · | shift on Monday, Tuesday, | | | | | |
| | | lay, and Friday for 6 Weeks | | | | | |
| | and as needed (PRN | - | | | | | |
| | and as nocaca (1 IC | •,• | | | | | |
| | The October 2024 7 | Freatment Administration | | | | | |
| | - | cated the treatment to the left | | | | | |
| | 1.0001a (1711c), mai | Table and another to the feet | 1 | | | | l |

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

2HNN11 Facility ID: 000056

If continuation sheet Page 21 of 49

| | IT OF DEFICIENCIES OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155131 | (X2) MULTIPLE A. BUILDING B. WING | CONSTRUCTION 00 | (X3) DATE SUR COMPLETE 10/22/202 | ED |
|--------------------------|--|---|-----------------------------------|---|--|---------------------------|
| | PROVIDER OR SUPPLIEF | . | 7935 | T ADDRESS, CITY, STATE, ZIP COD CALUMET AVE STER, IN 46321 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIEN REGULATORY OF | STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROI DEFICIENCY) | BE CO | (X5) OMPLETION DATE |
| | side of the resident' completed as order | s face was signed out as being ed. | | | | |
| | 10/10/24, indicated skin cancer to the le | ian Progress Note, dated the resident had a basal cell eft side of his face that meters (cm) by 3.5 cm x 1.0 cm. | | | | |
| | indicated the reside area to the lower ja | d 8/20/24 at 1:10 p.m., nt continued to pick at the w after he was reminded not to the spread of infection. | | | | |
| | | d 9/2/24 at 3:52 p.m., indicated tking at the area to the lower | | | | |
| | indicated the treatm resident's face was keep the dressing o reminded of the im | d 10/16/24 at 9:15 a.m., nent to the side of the completed but he refused to n. The resident had been portance of keeping the aide with infection but the keep it on. | | | | |
| | Assistant Director of the resident did have | or on 10/18/24 at 11:14 a.m., the of Nursing (ADON) indicated to a history of removing the jaw and he thought a care plan | | | | |
| | care plan that was of the resident display repetitively scratch | 56 a.m., the ADON presented a lated 10/16/24, which indicated ed anxious behaviors by ing at his wound and he was not orders by removing his ar basis. | | | | |
| | | plan prior to 10/16/24 vior of the resident removing | | | | |

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

2HNN11 Facility ID: 000056

If continuation sheet Page 22 of 49

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

PRINTED: 11/19/2024 FORM APPROVED OMB NO. 0938-039

| | IT OF DEFICIENCIES OF CORRECTION | XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155131 | (X2) MULT A. BUILI B. WING | DING | NSTRUCTION 00 | (X3) DATE : COMPL 10/22/ | ETED |
|--------------------------|--|--|---|-------------------|--|--------------------------------|----------------------------|
| | PROVIDER OR SUPPLIEI ER MED-INN | . | STREET ADDRESS, CITY, STATE, ZIP COD 7935 CALUMET AVE MUNSTER, IN 46321 | | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIEN | STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION | PR | ID EFIX CAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY) | ΤE | (X5) COMPLETION DATE |
| TAG | his dressing on a re observations on 10/10/17/24 at 9:50 a. Resident 6 was obs and geri sleeves (properties of the properties of the prope | gular basis. 3. During random (16/24 at 11:32 a.m. and on m., 11:36 a.m., and 2:30 p.m., erved wearing short sleeves rotective skin coverings) to a times, the resident was all and purple bruised area to the re her elbow. Ident 6 was reviewed on m. Diagnoses included, but a trial fibrillation, heart failure, asorder, reduced mobility, a late onset, dementia with od pressure, and adult failure Imum Data Set (MDS) (0/2/24, indicated the resident act for daily decision making. It is a substantial to maximal sonal hygiene and received and thinner) medication. Sed on 6/21/23, indicated the tential for complications alant therapy use. The observe and report adverse ruising and do a skin ity protocol. Indicated 3/3/24, indicated skin of be completed weekly and re to be documented per | | AG | DEFICIENCY) | | DATE |
| | Xarelto (an anticoa | dated 7/29/24, indicated gulant medication) 15 we 1 tablet by mouth one time a | | | | | |

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

2HNN11 Facility ID: 000056

If continuation sheet Page 23 of 49

| STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155131 | | (X2) MULTIPLE CO A. BUILDING B. WING | onstruction <u>00</u> | (X3) DATE SURVEY COMPLETED 10/22/2024 | |
|--|---|---|--------------------------|--|---------------|
| | PROVIDER OR SUPPLIEF | | 7935 C | ADDRESS, CITY, STATE, ZIP COD CALUMET AVE TER, IN 46321 | |
| (X4) ID PREFIX TAG | (EACH DEFICIEN | STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD IS CROSS-REFERENCED TO THE APPROP DEFICIENCY) | BE COMPLETION |
| | | on under skin observations, e no areas checked for 10/1 | | | |
| | indicated the reside today and bruising | e, dated 10/15/24 at 8:31 a.m., nt was seen by wound care to the right arm/hand had r recommended monitoring at | | | |
| | A Weekly Skin Obs | servation, dated 10/12/24, cin issues. | | | |
| | | mentation of the bruised area in nursing progress notes. | | | |
| | The resident had a s | shower on 10/15/24 and a on 10/16-10/18/24. | | | |
| | indicated she was n | on 10/18/24 at 11:15 a.m., RN 1 ot made aware the resident o her upper left arm and she s the area now. | | | |
| | Second Floor Unit l bruised very easily purpura (a condition spots or patches to a | on 10/18/24 at 11:30 a.m., the Manager indicated the resident and had the diagnoses of a that causes red or purple appear on the skin or in), but she would assess the | | | |
| | indicated the reside left arm right above centimeters (cm) by unsure of how she g the resident was no | at 10/18/24 at 12:01 p.m., In that a reddened area to the It the elbow that measured 2.5 If 2.3 cm. The resident was got it and upon assessment It the televise the leaning to one side in It placement of the bruise | | | |

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

2HNN11 Facility ID: 000056

If continuation sheet Page 24 of 49

| STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA | | (X2) MULTIPLE CONSTRUCTION (X3) DATE | | SURVEY | | | | |
|--|--|--------------------------------------|----------|----------|--|--------|------------|--|
| AND PLAN | OF CORRECTION | IDENTIFICATION NUMBER | A. BU | ILDING | 00 | COMPL | COMPLETED | |
| | | 155131 | B. WI | B. WING | | 10/22/ | 10/22/2024 | |
| | | | <u> </u> | CTDEET A | DDBECC CITY CTATE ZID COD | | | |
| NAME OF P | ROVIDER OR SUPPLIER | 1 | | | ADDRESS, CITY, STATE, ZIP COD | | | |
| MALINIOTE | D MED INN | | | | ALUMET AVE | | | |
| MUNSIE | R MED-INN | | | MUNSI | ER, IN 46321 | | | |
| (X4) ID | SUMMARY | STATEMENT OF DEFICIENCIE | | ID | PROVIDER'S PLAN OF CORRECTION | | (X5) | |
| PREFIX | (EACH DEFICIEN | CY MUST BE PRECEDED BY FULL | 1 | PREFIX | (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA | TE | COMPLETION | |
| TAG | REGULATORY OR | LSC IDENTIFYING INFORMATION | | TAG | DEFICIENCY) | | DATE | |
| | matched directly to | where the arm rest was on the | | | | | | |
| | wheelchair. Physica | al Therapy was asked to assess | | | | | | |
| | the resident's sitting | position and wheelchair. | | | | | | |
| | _ | eement that the bruise met the | | | | | | |
| | height of the arm rest and padded the arm rests. | | | | | | | |
| | 8 | 1 | | | | | | |
| | During an interview | on 10/18/24 at 2:45 p.m., the | | | | | | |
| | _ | was informed of the bruise | | | | | | |
| | _ | al information to provide. | | | | | | |
| | | | | | | | | |
| | The current 9/1/20 ' | "Skin Condition Assessment | | | | | | |
| | | licy, indicated each resident | | | | | | |
| would be observed for skin breakdown daily during care and on the assigned bath day by the | | | | | | | | |
| | | | | | | | | |
| | CNA. Changes should be promptly reported to | | | | | | | |
| | _ | no would perform the detailed | | | | | | |
| | assessment. | to would perform the detailed | | | | | | |
| | assessment. | | | | | | | |
| | 3.1-37(a) | | | | | ļ | | |
| | 3.1 37(u) | | | | | | | |
| F 0686 | 483.25(b)(1)(i)(ii) | | | | | | | |
| SS=D | | Prevent/Heal Pressure | | | | | | |
| Bldg. 00 | Ulcer | | | | | | | |
| | | on, record review, and | F 06 | 86 | Annual Survey: 10/22/2024 | | 11/08/2024 | |
| | | ty failed to ensure preventative | 1 00 | 80 | Munster Med-Inn | | 11/06/2024 | |
| | | lace to prevent pressure ulcers | | | Please accept the following as | the | | |
| | _ | opment of a new pressure area | | | facility's credible allegation of | , uio | | |
| | | ear for 1 of 2 residents | | | compliance. This plan of | ļ | | |
| | | re ulcers. (Resident 129) | | | correction does not constitute | on | | |
| | reviewed for pressu | ite dicers. (Resident 127) | | | admission of guilt or liability by | | | |
| | Finding includes: | | | | | | | |
| | i manig merades. | | | | facility and is submitted only ir response to the regulatory | | | |
| | During a random ob | oservation on 10/17/24 at 2:25 | | | requirement. | ļ | | |
| | _ | was observed up and dressed | | | F686 Treatment/Svcs to | ļ | | |
| | * | own the hallway. The resident | | | Prevent/Heal Pressure Ulcers | ļ | | |
| | • | | | | | | | |
| | | y shoes and did not have his | | | What corrective action(s) will be | | | |
| | | told the resident she would | | | accomplished for those reside | | | |
| | | ning on his feet and instructed | | | found to have been affected by | y tne | | |
| | - | is room. As the resident turned | | | deficient practice; | ļ | | |
| | his wheelchair arou | nd, his left ear was observed | | | Resident 129's skin was | ļ | | |

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

2HNN11 Facility ID: 000056

If continuation sheet Page 25 of 49

| STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA | | (X2) MULTIPLE CONSTRUCTION | | | (X3) DATE SURVEY | | |
|--|---|---------------------------------|-------|----------|---|-------|------------|
| AND PLAN | OF CORRECTION | IDENTIFICATION NUMBER | A. BU | ЛLDING | 00 | COMPL | ETED |
| | | 155131 | B. W | ING _ | | 10/22 | /2024 |
| | | l | | STREET / | ADDRESS, CITY, STATE, ZIP COD | | |
| NAME OF F | PROVIDER OR SUPPLIEF | ₹ | | | ALUMET AVE | | |
| MUNISTE | R MED-INN | | | | TER, IN 46321 | | |
| | | | | WIGHT | 1 - 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 | | |
| (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 BE CROSS-REFERENCED TO THE APPROPRIA | TE | COMPLETION |
| TAG | | R LSC IDENTIFYING INFORMATION | - | TAG | DEFICIENCY | | DATE |
| | with dried blood behind it. | | | | immediately assessed. Reside | | |
| | | | | | 129's MD was notified, and or | | |
| | On 10/17/24 at 3:00 p.m., the resident was | | | | were obtained and implement | | |
| | | m wearing oxygen via a nasal | | | for newly identified pressure u | | |
| | | ne, he was asked to pull back | | | How the facility will identify oth | | |
| | 1 | the area behind the ear could | | | residents having the potential | | |
| | | a behind the ear was open with | | | be affected by the same defici | | |
| | | l blood. The resident was | | | practice and what corrective a | ction | |
| | asked to pull back his left ear lobe and there was | | | | will be taken; | | |
| | | that ear as well. The resident | | | All residents with pressure ulc | | |
| | indicated both areas were painful and had been | | | | have the potential to be affect | ea | |
| | there "for a while." There were no padded protectors observed over the oxygen tubing to | | | | by the same alleged deficient | | |
| | 1 ^ | over the oxygen tubing to | | | practice. | _ | |
| | protect his ears. | | | | What measures will be put into | | |
| | On 10/17/24 at 2:0/ | p.m., LPN 1 was asked to asses | | | place or what systemic change will be made to ensure that the | | |
| | | At that time, she removed the | | | | | |
| | | behind his ears and both | | | deficient practice does not rec Nurses were re-educated on t | | |
| | | e observed. The oxygen | | | following: | HE | |
| | 1 ~ | around the resident's ears, | | | · Obtaining orders and | | |
| | there were indentate | | | | implementing treatment for | | |
| | there were indentati | ions on his face. | | | pressure/new skin conditions. | | |
| | During an interview | v at that time, LPN 1 indicated | | | Notifying MD and resident | | |
| | _ | e resident had any pressure | | | responsible party of new | | |
| | | ars and she would contact the | | | pressure/skin conditions. | | |
| | | ess and treat the wounds. | | | Assistive staff were re-educate | ed | |
| | | | | | on: | Ju | |
| | The record for Resi | dent 129 was reviewed on | | | · Notifying the nurse immediat | elv | |
| | | n. The resident was admitted to | | | when a treatment has become | - | |
| | | 24 and his diagnoses included, | | | soiled or detached from wound | | |
| | | d to, COPD (chronic | | | How the corrective action(s) w | | |
| | | ary disease), chronic | | | monitored to ensure the defici | | |
| | respiratory failure, | heart failure, heart disease, | | | practice will not recur, i.e., wh | at | |
| | anxiety, palliative of | are, dependence on oxygen, | | | quality assurance programs w | | |
| | and chronic pain. | | | | put into place; | | |
| | _ | | | | Wound nurse/designee will | | |
| | The 9/1/24 Admiss | ion Minimum Data Set (MDS) | | | randomly audit 5 residents | | |
| | assessment indicated the resident was cognitively | | | | identified at risk for skin | | |
| | intact for daily deci | sion making. The resident | | | breakdown and residents with | | |
| | needed substantial/maximal assist for bathing and | | | | existing skin breakdown to en | sure | |

| STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA | | (X2) MUI | (X2) MULTIPLE CONSTRUCTION | | | (X3) DATE SURVEY | | |
|--|---|---|----------------------------|-------------------|--|------------------|------------|--|
| AND PLAN | OF CORRECTION | IDENTIFICATION NUMBER | A. BUILDING 00 COMPLETED | | | ETED | | |
| | | 155131 | B. WING 10/22/2024 | | | | 2024 | |
| NAME OF I | DDOVIDED OF CLIDDLES | | - | STREET A | ADDRESS, CITY, STATE, ZIP COD | | | |
| NAME OF F | PROVIDER OR SUPPLIEF | C | | | ALUMET AVE | | | |
| MUNSTE | ER MED-INN | | | MUNSTER, IN 46321 | | | | |
| (X4) ID | | STATEMENT OF DEFICIENCIE | | ID | PROVIDER'S PLAN OF CORRECTION | | (X5) | |
| PREFIX | ` | CY MUST BE PRECEDED BY FULL | P | REFIX | (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA | TE | COMPLETION | |
| TAG | | R LSC IDENTIFYING INFORMATION | + | TAG | DEFICIENCY) | 1 | DATE | |
| | personal hygiene. I ulcers. | The resident had no pressure | | | skin conditions are documented | ea | | |
| | uiceis. | | | | and orders are obtained, and treatments are in place per ord | dere | | |
| | A Care Plan, dated | 8/27/24, indicated the resident | | | Director of Nursing/designee | | | |
| | | r pressure ulcers. The | | | present a summary of the aud | | | |
| | _ | monitor for signs and | | | to the Quality Assurance | | | |
| | | reakdown and notify the | | | committee monthly for 6 mont | hs. | | |
| | physician of changes. | | | | Thereafter, if determined by the | ie | | |
| | | | | | Quality Assurance committee, | | | |
| | | in Review Assessment was | | | auditing and monitoring will be | • | | |
| | dated 10/14/24, and only mentioned the resident | | | | done quarterly and present | | | |
| | had shingles. | | | | quarterly at the QA meeting. | | | |
| | The resident receive | ed a complete bed bath on | | | Monitoring will be on going. Date by which systemic | | | |
| | | /1-10/4, 10/6-10/9, 10/12-10/14, | | | corrections will be completed: | | | |
| | and 10/16-10/17/24 | | | | 11/8/2024 | | | |
| | | | | | | | | |
| | | dated 8/26/24, indicated the | | | | | | |
| | | e weekly skin assessments | | | | | | |
| | | s were to be documented per | | | | | | |
| | protocol. | | | | | | | |
| | There was no order | for protective padding for the | | | | | | |
| | oxygen tubing. | - , , | | | | | | |
| | | | | | | | | |
| | | ent by the wound nurse, | | | | | | |
| | | icated the following: | | | | | | |
| | _ | with 65% of Epithelial (pale | | | | | | |
| | | serous drainage, and measured a) by 1.50 cm by 0.1 cm. | | | | | | |
| | 1 | 3, with 65% of Epithelial (pale | | | | | | |
| | | serous drainage, and measured | | | | | | |
| | 1.5 cm by 0.3 cm by | _ | | | | | | |
| | | Stage 3, with 20% Epithelial | | | | | | |
| | | 0%, and measured 0.8 cm by 0.5 | | | | | | |
| | cm by 0.2 cm. | | | | | | | |
| | A Wound Note, dated 10/17/24 at 6:31 p.m., | | | | | | | |
| | | nt was seen by wound care | | | | | | |
| today to follow up on new open areas to his | | | | | | | | |

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

2HNN11 Facility ID: 000056

If continuation sheet Page 27 of 49

| STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA | | (X2) M | (X2) MULTIPLE CONSTRUCTION | | | (X3) DATE SURVEY | | |
|--|--|--|----------------------------|-------------------|--|------------------|------------|--|
| AND PLAN | OF CORRECTION | IDENTIFICATION NUMBER | A. BU | JILDING | 00 | COMPLETED | | |
| | | 155131 | B. W | ING | | 10/22/ | /2024 | |
| NAME OF I | PROVIDER OR SUPPLIEI | 2 | | | ADDRESS, CITY, STATE, ZIP COD ALUMET AVE | | | |
| MUNSTE | ER MED-INN | | | MUNSTER, 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 | ATE | COMPLETION | |
| TAG | | R LSC IDENTIFYING INFORMATION | | TAG | DEFICIENCY) | | DATE | |
| | bilateral ears as rep | - | | | | | | |
| | | ds were noted to his bilateral | | | | | | |
| | | f the nose from the oxygen t was noted in some minor | | | | | | |
| | _ | ese areas. New treatments were | | | | | | |
| | | oxygen tubing protectors were | | | | | | |
| | placed to the oxygen tubing and education was done with the resident. During an interview on 10/17/24 at 3:12 p.m., the Wound Nurse indicated the Wound Physician had seen him earlier and he did not complain about the areas. She was not aware he had open | | | | | | | |
| | | | | | | | | |
| | | | | | | | | |
| | | | | | | | | |
| | | | | | | | | |
| | | | | | | | | |
| | | | | | | | | |
| | areas to his ears. | | | | | | | |
| | Second Floor Unit had a skin assessme | w on 10/17/24 at 3:30 p.m., the Manager indicated the resident ent on 10/14/24 and the e not there. She had no ion to provide. | | | | | | |
| | and Monitoring" po would be observed during care and on CNA. Changes sho | "Skin Condition Assessment blicy, indicated each resident for skin breakdown daily the assigned bath day by the uld be promptly reported to no would perform the detailed | | | | | | |
| | 3.1-40(a)(1) | | | | | | | |
| F 0689 SS=G Bldg. 00 | interview, the facili lift straps were safe dependent resident falls. (Resident B) | sion/Devices ration, record review, and ity failed to ensure mechanical r for use prior to a transfer of a for 1 of 1 resident reviewed for This deficient practice resulted during a transfer, the resident | F 00 | 689 | Munster Med INN Annual Survey: 10/22/2024 Please accept the following as facility's credible allegation of compliance. This plan of correction does not constitute | | 11/08/2024 | |

| STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA | | (X2) MULTIPLE CONSTRUCTION | | | (X3) DATE SURVEY | | |
|--|--|---|-------|----------|--|--------|------------|
| AND PLAN | OF CORRECTION | IDENTIFICATION NUMBER | A. BU | JILDING | 00 | COMPL | ETED |
| | | 155131 | B. W | ING | | 10/22/ | 2024 |
| | | | 1 | STREET 4 | ADDRESS, CITY, STATE, ZIP COD | | |
| NAME OF F | PROVIDER OR SUPPLIEF | ₹ | | | ALUMET AVE | | |
| MUNSTF | R MED-INN | | | | TER, IN 46321 | | |
| | Г | | 1 | | T | | |
| (X4) ID | | STATEMENT OF DEFICIENCIE | | ID | PROVIDER'S PLAN OF CORRECTION | | (X5) |
| PREFIX | | ICY MUST BE PRECEDED BY FULL | | PREFIX | (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA | TE | COMPLETION |
| TAG | | R LSC IDENTIFYING INFORMATION | + | TAG | DEFICIENCY) | | DATE |
| | falling from the lift, and the resident sustaining a | | | | admission of guilt or liability by | • | |
| | left femur fracture. | | | | facility and is submitted only in | า | |
| | D D1 | | | | response to the regulatory | | |
| | | vation, record review, and ity failed to ensure hot water | | | requirement. | | |
| | | below 120 degrees Fahrenheit | | | F689 Free of Accident | | |
| | _ | oughout the facility. (The 5th | | | Hazards/Supervision/Devices | | |
| | and 2nd floors) | bugnout the facility. (The 3th | | | What corrective action(s) will be accomplished for those reside | | |
| | and 2nd 110015) | | | | found to have been affected b | | |
| | Findings include: | | | | deficient practice; | y u ie | |
| | Findings include. | | | | · On 10/5/2024 a full house au | ıdit | |
| | A. A confidential interview indicated Resident B | | | | of all hoyer lift pads was | adit | |
| | fell from a mechanical lift when the sling straps | | | | completed to ensure no pads | have | |
| | | lent sustained a leg fracture. | | | any tears, rips, or worn areas. | | |
| | , | | | | · Hoyer/mechanical lift educat | | |
| | On 10/15/24 at 2:54 | 4 p.m., Resident B was observed | | | including return demonstration | | |
| | | immobilizer was observed on | | | was competed with clinical sta | | |
| | the resident's left le | | | | · The facility hot water tank | | |
| | | | | | temperature was immediately | | |
| | The record for Resi | dent B was reviewed on | | | decreased, and the water | | |
| | 10/17/24 at 1:26 p.1 | m. Diagnoses included, but | | | temperature was checked on | all | |
| | were not limited to, | , displaced oblique fracture of | | | floors every hour x 4 hours to | | |
| | the shaft of the left | femur, vascular dementia with | | | ensure levels were maintained | d | |
| | behavior disturbance | | | | within the appropriate range. | | |
| | protein-calorie mali | nutrition, and orthopedic | | | · A service call was placed to | | |
| | aftercare. | | | | Precision Service to check the | • | |
| | | | | | water heater and related | | |
| | | S assessment, dated 8/25/24, | | | components | | |
| | | ent was cognitively impaired for | | | · The facility Medical Director | | |
| | | ing and used a mechanical lift | | | updated, and a recommendati | | |
| | | esident was dependent on staff | | | was given to supply each unit | with | |
| | · · | d transfers. There had been no | | | a thermometer to test water | | |
| | falls since the last a | issessment. | | | temperature if they suspect | | |
| | A Coro Diam datal | 0/2/24 indicated the resident | | | temperatures are too warm. | n all | |
| | | 9/3/24, indicated the resident | | | Thermometers were placed or | n all | |
| | was at risk for falls | and injury from falls. | | | units. | | |
| | Numaola Notas d-t- | d 10/5/24 at 0:00 a indicated | | | How the facility will identify oth | | |
| | | d 10/5/24 at 9:00 a.m., indicated noned to the resident's room. | | | residents having the potential | | |
| | | o were in the resident's room at | | | be affected by the same defici | | |
| | I THE TWO CNA'S WIN | o were in the resident's room at | 1 | | practice and what corrective a | เนเดท | |

| STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA | | (X2) MULTIPLE CONSTRUCTION | | | (X3) DATE SURVEY | | | |
|--|--|-----------------------------------|-------|-----------------------|---|--|------------|--|
| AND PLAN | OF CORRECTION | IDENTIFICATION NUMBER | A. BU | A. BUILDING <u>00</u> | | COMPL | COMPLETED | |
| | | 155131 | B. W | ING | | 10/22/ | /2024 | |
| | | | | STREET | ADDRESS, CITY, STATE, ZIP COD | <u>. </u> | | |
| NAME OF I | PROVIDER OR SUPPLIE | R | | | ALUMET AVE | | | |
| MUNISTE | ER MED-INN | | | | ΓER, IN 46321 | | | |
| MONOTER MED-INN | | | WICHG | | | | | |
| (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 | ΛΤΕ. | COMPLETION | |
| TAG | | R LSC IDENTIFYING INFORMATION | | TAG | DEFICIENCY) | | DATE | |
| | | the resident fell. The CNA's | | | will be taken; | | | |
| | indicated the resident fell during a transfer from | | | | All residents have the potentia | al to | | |
| | | elchair while using the | | | be affected by the same alleg | ed | | |
| | | e mechanical sling strap broke | | | deficient practice. | | | |
| | | eft leg fell from the sling. The | | | What measures will be put into | 0 | | |
| | _ | aining of pain to the left leg. | | | place or what systemic chang | es | | |
| | 1 | notified, orders were obtained | | | will be made to ensure that the | е | | |
| | | t to the emergency room for | | | deficient practice does not rec | :ur; | | |
| | evaluation, and 911 | was contacted for transport. | | | Staff were in-serviced on the | | | |
| | | | | | following related to mechanica | al | | |
| | Hospital x-ray results of the left knee, dated | | | | lifts: | | | |
| | 10/5/24, indicated the resident had a new left | | | | · Hoyer education with return | | | |
| femur fracture. The resident was identified as | | | | demonstration | | | | |
| | having severely de | mineralized bones. | | | · Checking hoyer pads for rips | ; , | | |
| | | | | | tears, and worn areas | | | |
| | | ompleted by the facility was | | | · Laundry staff to inspect hove | er: | | |
| | | investigation documentation | | | pads with each wash and | | | |
| | | members were transferring the | | | document each inspection | | | |
| | | chanical lift. There were no | | | Staff were in-serviced on the | | | |
| | _ | mechanical sling prior to | | | following related to water | | | |
| | | r. As staff started to lift the | | | temperatures: | | | |
| | | them, the blue strap on the left | | | · Acceptable water temperatur | res | | |
| | | resident's leg hit the floor. The | | | range | | | |
| | | owered to the floor. As the | | | · Notifying maintenance and t | ne | | |
| | | unhooked from the mechanical | | | administrator if the water | | | |
| | | e blue straps tore. Both | | | temperature is below or above | e the | | |
| | | g with the transfer indicated | | | acceptable range. | | | |
| | | re any fraying or tears to the | | | How the corrective action(s) w | | | |
| | | g pad prior to starting the | | | monitored to ensure the defici | | | |
| | | no documentation which | | | practice will not recur, i.e., wh | | | |
| | | anical lift sling straps were | | | quality assurance programs w | ill be | | |
| | checked prior to the | e transfer. | | | put into place; | | | |
| | | 1 | | | Administrator/designee will | | | |
| | | dent audit, dated 10/5/24, | | | audit/inspect 5 hoyer lift pads | | | |
| | | tional mechanical lift sling was | | | weekly to ensure they are in g | jood | | |
| | | lamage, was taken out of | | | condition. | | | |
| | service, and replace | ed. | | | The maintenance | | | |
| | | | | | director/designee will check w | | | |
| | _ | , staff were re-educated on the | | | temperature 5 times per week | | | |
| | use of the mechanical lift and maintaining slings, | | | | alternating floors to ensure wa | ater | | |

| STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA | | (X2) MULTIPLE CONSTRUCTION | | | (X3) DATE SURVEY | | |
|--|-----------------------|----------------------------------|-------|-----------|--|--------|------------|
| AND PLAN | OF CORRECTION | IDENTIFICATION NUMBER | A. BU | JILDING | 00 | COMPL | ETED |
| | | 155131 | B. WI | ING | | 10/22/ | 2024 |
| | | | | CTD FFT A | DDDEGG OFFI GTATE ZID COD | | |
| NAME OF P | PROVIDER OR SUPPLIER | 3 | | | ADDRESS, CITY, STATE, ZIP COD ALUMET AVE | | |
| NALINIOTE | D MED INN | | | | | | |
| MUNSIE | R MED-INN | | | MUNSI | ER, IN 46321 | | |
| (X4) ID | SUMMARY | 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 | тс | COMPLETION |
| TAG | REGULATORY OF | LSC IDENTIFYING INFORMATION | | TAG | DEFICIENCY) | | DATE |
| | such as checking fo | r damage before use. Ongoing | | | temperatures are maintained | | |
| | audits of the mecha | nical lift sling pads were | | | within the appropriate range. | | |
| | | taff were responsible for | | | The Administrator/designee w | ill | |
| | | s when they would need to be | | | present a summary of the aud | | |
| | | ng was torn or frayed, the sling | | | to the Quality Assurance | | |
| | | of service. Staff were also to | | | committee monthly for 6 mont | hs. | |
| | | ical lift slings prior to use. | | | Thereafter, if determined by the | | |
| | | | | | Quality Assurance committee, | | |
| | A Fall Interdisciplin | nary Team (IDT) Note, dated | | | auditing and monitoring will be | | |
| | _ | n., indicated the resident was | | | done quarterly and present | - | |
| | | CNA's via the mechanical lift | | | quarterly at the QA meeting. | | |
| | 1 | wheelchair. The resident had a | | | Monitoring will be on going. | | |
| | | e floor. Upon assessment, the | | | Date by which systemic | | |
| | | d of pain to the left hip. The | | | corrections will be completed: | | |
| | _ | oved and their position was | | | 11/8/2024 | | |
| | | MS arrived. The root cause of | | | 11/0/2024 | | |
| | | uring a transfer from the bed to | | | | | |
| | | DT note did not indicate the | | | | | |
| | | oken mechanical sling strap. | | | | | |
| | lan was due to a ore | oken mechanical sinig suap. | | | | | |
| | Dhysician's Orders | dated 10/11/24, indicated the | | | | | |
| | 1 - | eight bearing to the left femur | | | | | |
| | | - | | | | | |
| | | nobilizer was to stay in place, | | | | | |
| | | ed for hygiene and skin | | | | | |
| | checks. | | | | | | |
| | A Como Diam data i | 10/14/24 indicated the manifest | | | | | |
| | | 10/14/24, indicated the resident | | | | | |
| | | plications, including changes in | | | | | |
| | | to oblique fracture of the left | | | | | |
| | _ | oding and surgical aftercare. | | | | | |
| | | led, but were not limited to, | | | | | |
| | | needs, be sure call light was | | | | | |
| | | espond promptly to all requests | | | | | |
| | for assistance. | | | | | | |
| | | 10/10/04 + 0.55 | | | | | |
| | | y on 10/18/24 at 2:55 p.m., CNA | | | | | |
| | | dent was transferred with two | | | | | |
| | | e CNA also indicated that the | | | | | |
| | | g was checked prior to | | | | | |
| | transferring the resi | dent and no frays were noted. | | | | | |

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

2HNN11 Facility ID: 000056

If continuation sheet Page 31 of 49

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

PRINTED: 11/19/2024 FORM APPROVED OMB NO. 0938-039

| | NT OF DEFICIENCIES OF CORRECTION | XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155131 | (X2) MULTIPLE CO A. BUILDING B. WING | onstruction 00 | (X3) DATE (COMPL 10/22/ | ETED | | |
|--------------------------|--|---|---|---|-------------------------|----------------------------|--|--|
| | PROVIDER OR SUPPLIEI | R | STREET ADDRESS, CITY, STATE, ZIP COD 7935 CALUMET AVE MUNSTER, 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 CORR (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE AP DEFICIENCY) | OULD BE | (X5) COMPLETION DATE | | |
| | Housekeeper 1 indivered not inspected prior to 10/5/24. Ho 10/5/2024, the slings and after the slings should inspect the sthem to dry. During paper, dated 10/202 dryer. The paper in slings were observed 10/2/24, 10/6/24, 10/17/24, and 10/20 paper indicated the damage between 10 damage between 10 damage between 10 damage between 10 damage straps prior to Laundry Supervisor was responsible for sling straps prior to Laundry Supervisor documentation coun mechanical lift sling January 2024 and 1 damage damage determined lift and through April 2024 October 2025. The audit sheets were in Supervisor to determine the su | v, on 10/22/24 at 8:35 a.m., the r indicated the laundry staff monitoring the mechanical lift and after 10/5/24. The r indicated he was not sure ld be provided to show the gs were inspected between | | | | | | |

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

2HNN11 Facility ID: 000056

If continuation sheet

Page 32 of 49

| STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA | | (X2) MULTIPLE CONSTRUCTION | | | (X3) DATE SURVEY | | |
|--|--|----------------------------------|--------------------------------|--------|--|-------|------------|
| AND PLAN | OF CORRECTION | IDENTIFICATION NUMBER | A. BUILDING <u>00</u> COMPLETE | | | ETED | |
| | | 155131 | B. WING | | | 10/22 | /2024 |
| | | | | CTREET | DDDFGG CITY CTATE ZID COD | | |
| NAME OF F | PROVIDER OR SUPPLIEF | ₹ | | | ADDRESS, CITY, STATE, ZIP COD | | |
| | | | | | ALUMET AVE | | |
| MUNSTER MED-INN | | | | MUNSI | ER, IN 46321 | | |
| (X4) ID | SUMMARY | STATEMENT OF DEFICIENCIE | | ID | BROWINEDIG BLAN OF CORRECTION | | (X5) |
| PREFIX | (EACH DEFICIEN | ICY MUST BE PRECEDED BY FULL | | PREFIX | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE | | COMPLETION |
| TAG | | R LSC IDENTIFYING INFORMATION | | TAG | CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY) | IE | DATE |
| | | slings were to be inspected | | | | | |
| | I | y fraying or tears were noted, | | | | | |
| | | taken out of service and | | | | | |
| | _ | ninistrator indicated the | | | | | |
| | 1 - | r stated the audits were being | | | | | |
| | | the incident and she took his | | | | | |
| | | | | | | | |
| | word for it, he did not provide her with any audit | | | | | | |
| | sheets. | | | | | | |
| | D | | | | | | |
| | | erview on 10/22/24 at 3:20 p.m., | | | | | |
| | the Laundry Supervisor indicated he may have | | | | | | |
| | 1 | l he didn't know why the May | | | | | |
| | _ | dit sheets were dated 2025. | | | | | |
| | | e may not have been wearing | | | | | |
| | 1 - | was why the wrong lines | | | | | |
| | | ne month of October, he did not | | | | | |
| | state that he or staff | f had checked them on those | | | | | |
| | dates. | | | | | | |
| | | | | | | | |
| | | policy related to the | | | | | |
| | | not specify how often the | | | | | |
| | Hoyer slings were t | to be inspected. | | | | | |
| | | | | | | | |
| | | rence, titled "Patient Lifts | | | | | |
| | Safety Guide," four | | | | | | |
| | | v/files/medical%20devices/pu | | | | | |
| | blished/Patient-Lift | s-Safety-Guide.pdf, indicated, | | | | | |
| | "Examine sling a | and attachment areas for tears, | | | | | |
| | holes and frayed se | ams. DO NOT USE sling with | | | | | |
| | any signs of wear | ." | | | | | |
| | | | | | | | |
| | | | | | | | |
| | B1. On 10/16/24 at | 11:25 a.m., the hot water | | | | | |
| | temperature in the b | oathroom of room 517 was hot | | | | | |
| | to touch. At 11:34 | a.m., the Maintenance | | | | | |
| | Supervisor arrived | on the fifth floor, which was | | | | | |
| | _ | y care unit, and checked the | | | | | |
| | · | The bathroom water | | | | | |
| | _ | n 517 registered 134.5 degrees | | | | | |
| | _ | 5 a.m., the Maintenance | | | | | |
| | | , | - 1 | | | | 1 |

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

2HNN11 Facility ID: 000056

If continuation sheet Page 33 of 49

| STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155131 | | (X2) MULTIPLE C A. BUILDING B. WING | onstruction 00 | (X3) DATE SURVEY COMPLETED 10/22/2024 | |
|--|---|--|-------------------|--|-----------------|
| | PROVIDER OR SUPPLIEI ER MED-INN | ₹ | 7935 (| ADDRESS, CITY, STATE, ZIP COD CALUMET AVE TER, IN 46321 | |
| (X4) ID PREFIX | | STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL | ID PREFIX | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI | (X5) COMPLETION |
| TAG | | R LSC IDENTIFYING INFORMATION | TAG | DEFICIENCY) | DATE |
| | _ | ed the bathroom hot water in 502. The temperature was 137 | | | |
| | Maintenance Super usually hotter on the down on the lower | v, on 10/16/24 at 11:40 a.m., the visor indicated the water was e fifth floor and it cooled floors due to the boiler being ifth floor. He also indicated he temperatures daily. | | | |
| | Observation of the 11:40 a.m., indicate 120 degrees Fahren tank was registering electronic temperat degrees Fahrenheit down at that time to 110-degrees Fahren Supervisor indicate the water to cool do set the thermostat to Maintenance Super thermostats should 110-115 degrees Fa | holding tanks on 10/16/24 at ed one water tank was holding at theit, and the second holding g 134 degrees Fahrenheit. The ture gauge was set at 134. The temperature was turned to register between 105- and theit. The Maintenance ed it would take some time for own and he did not know who to 134 degrees Fahrenheit. The twisor indicated the have been set between threnheit to ensure the aintained between 100-120 | | | |
| | Administrator indic were being checked had already been in the water temperatu indicated the Maint | v on 10/16/24 at 1:30 p.m., the cated the water temperatures d hourly on all units and staff aserviced related to checking ares. The Administrator tenance Supervisor was cking the water temperature | | | |
| | the Administrator, | ure Audit Sheet, provided by indicated on 10/16/24 at 1:02 water temperature in room 502 | | | |

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

2HNN11 Facility ID: 000056

If continuation sheet Page 34 of 49

| STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155131 | | IDENTIFICATION NUMBER | (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY A. BUILDING 00 COMPLETED B. WING 10/22/2024 | | | ETED | | |
|--|---|---|---|---|-------------|------|--------------------|--|
| | | 155131 | B. W. | ING 10/22/2024 | | | | |
| | PROVIDER OR SUPPLIER | R | STREET ADDRESS, CITY, STATE, ZIP COD 7935 CALUMET AVE MUNSTER, IN 46321 | | | | | |
| (X4) ID PREFIX | | STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL | | ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE | | TE | (X5) COMPLETION | |
| TAG | REGULATORY OF | R LSC IDENTIFYING INFORMATION | | TAG | DEFICIENCY) | 16 | DATE | |
| | temperature in the b | grees Fahrenheit. t 11:36 a.m., the hot water pathroom of room 216 was hot a.m., the Second Floor Unit | | | | | | |
| | Manager felt the water and agreed it was hot to touch, as she had to pull her hand away from the running water. | | | | | | | |
| | a.m. and 11:55 a.m. observed to measur | ion, on 10/16/24 between 11:45 , the Maintenance Director was e the hot water temperature on | | | | | | |
| | - Room 212: 137 de - Room 215: 136 de - Room 215: 136 de - Room 216: 137 de | egrees Fahrenheit. egrees Fahrenheit. | | | | | | |
| | 10:30 a.m., the Mai observed to measur random rooms on the temperatures measu Water temperatures | mental Tour, on 10/22/24 at intenance Supervisor was e hot water temperatures in the second floor. The water ared 114 degrees Fahrenheit. In random rooms on the fifth 1.5 degrees Fahrenheit. | | | | | | |
| | Maintenance Super was torn, was imme tank temperature was | v, on 10/22/24 at 11:00 a.m., the visor indicated a water line ediately repaired, the hot water as turned down, and the water holding tank was 115 degrees | | | | | | |
| | This citation relates IN00444914, and II | s to Complaints IN00444806, N00445179. | | | | | | |
| | 3.1-45(a)(1) 3.1-45(a)(2) | | | | | | | |
| F 0693 SS=D | 483.25(g)(4)(5) Tube Feeding Mg | mt/Restore Eating Skills | | | | | | |

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

2HNN11 Facility ID: 000056

If continuation sheet Page 35 of 49

| STATEMENT OF DEFICIENCIES | | X1) PROVIDER/SUPPLIER/CLIA | (X2) MULTIPLE CONSTRUCTION (X3) DATE | | (X3) DATE S | URVEY | |
|---------------------------|---|----------------------------------|--------------------------------------|----------|--|---------|------------|
| AND PLAN | OF CORRECTION | IDENTIFICATION NUMBER | A. BU | ILDING | 00 | COMPLE | ETED |
| | | 155131 | B. WI | NG | | 10/22/2 | 2024 |
| | | | | STREET A | ADDRESS, CITY, STATE, ZIP COD | | |
| NAME OF P | ROVIDER OR SUPPLIER | L . | | | ALUMET AVE | | |
| MUNSTE | R MED-INN | | | | ΓER, IN 46321 | | |
| (X4) ID | SUMMARY | 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 | ATE | COMPLETION |
| TAG | REGULATORY OR | LISC IDENTIFYING INFORMATION | | TAG | DEFICIENCY) | | DATE |
| Bldg. 00 | | | | | | | |
| | | on, record review, and | F 06 | 593 | Munster Med-Inn | | 11/08/2024 |
| | | ty failed to ensure enteral tube | | | Annual Survey: 10/22/2024 | | |
| | _ | ing at the correct time through | | | Please accept the following a | | |
| | | nserted directly into the | | | facility's credible allegation of | | |
| | | n) for 1 of 1 resident reviewed | | | compliance. This plan of | | |
| | for tube feeding. (R | esident 113) | | | correction does not constitute | | |
| | E' 1' ' 1 1 | | | | admission of guilt or liability b | - | |
| | Finding includes: | | | | facility and is submitted only i | n | |
| | O:: 10/10/24 + 0.25 | 7 D: 1 112 | | | response to the regulatory | | |
| | On 10/18/24 at 9:37 a.m., Resident 113 was observed lying in bed with the head of the bed | | | | requirement. | | |
| | | | | | F693 Tube Feeding Managen | nent | |
| | (HOB) elevated. The resident's tube feeding was | | | | Restore Eating Skills | | |
| | running at 70 milliliter/hour (ml/hr). The tube feeding bottle was dated 10/17/24. Written on the | | | | What corrective action(s) will | | |
| | _ | vith pen was a start time of | | | accomplished for those reside | | |
| | | end time of 6:00 a.m. At 10:09 | | | found to have been affected b | by the | |
| | | ng dated 10/17/24 was still | | | deficient practice; | oioon | |
| | | There was a new tube feeding | | | R113 was assessed and Physwas notified. Tube feeding was | | |
| | - | the bedside table that was | | | administered per order. | 15 | |
| | _ | indicated a start time of 10:00 | | | How the facility will identify ot | hor | |
| | | , the tube feeding was shut off | | | residents having the potential | | |
| | | esident's medication pass. At | | | be affected by the same defic | | |
| | | feeding bottle dated 10/18/24 | | | practice and what corrective a | | |
| | was on and running | | | | will be taken; | action | |
| | | | | | All residents requiring tube fe | edina | |
| | During an interview | at the time, QMA 1 indicated | | | have the potential to be affect | - | |
| | _ | 10:00 a.m. tube feeding for the | | | by the alleged deficient practi | | |
| | day and changed ou | 9 | | | What measures will be put int | | |
| | | - | | | place or what systemic change | | |
| | The record for Resid | dent 113 was reviewed on | | | will be made to ensure that th | | |
| | 10/18/24 at 10:00 a. | .m. Diagnoses included, but | | | deficient practice does not red | | |
| | | hemiplegia (paralysis on one | | | Nursing staff were educated of | | |
| | | roke, depression, dementia, | | | · Ensuring tube feeding is | | |
| | anxiety, dysphagia (| (difficulty swallowing), and | | | administered as ordered. | | |
| | diabetes. | | | | How the corrective action(s) v | will be | |
| | | | | | monitored to ensure the defic | ient | |
| | The Quarterly Minis | mum Data Set (MDS) | | | practice will not recur, i.e., wh | nat | |
| | assessment, dated 7 | /29/24, indicated the resident | | | quality assurance programs v | vill be | |
| | was severely impair | red for daily decision making | | | put into place; | | |

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

2HNN11 Facility ID: 000056

If continuation sheet

Page 36 of 49

| STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA | | , , | (X2) MULTIPLE CONSTRUCTION | | | (X3) DATE SURVEY | |
|--|----------------------|---|----------------------------|--------|--|------------------|------------|
| AND PLAN | OF CORRECTION | IDENTIFICATION NUMBER | | LDING | 00 | COMPL | |
| | | 155131 | B. WIN | ··· | | 10/22/ | /2024 |
| NAME OF P | PROVIDER OR SUPPLIE | | | | ADDRESS, CITY, STATE, ZIP COD | | |
| MUNSTE | R MED-INN | | | | ALUMET AVE ER, IN 46321 | | |
| (X4) ID | SUMMARY | STATEMENT OF DEFICIENCIE | <u> </u> | ID | PROVIDER'S PLAN OF CORRECTION | | (X5) |
| PREFIX | (EACH DEFICIEN | NCY MUST BE PRECEDED BY FULL | I | PREFIX | (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA | TE | COMPLETION |
| TAG | | R LSC IDENTIFYING INFORMATION | | TAG | DEFICIENCY) | | DATE |
| | and had a feeding t | | | | Nursing Managers will audit 3 residents receiving tube feedi | ng 3 | |
| | | 7/29/24, indicated the resident | | | times per week to ensure form | | |
| | | nutrition (poor nutrition) and | | | is being administered as orde | | |
| | | be feeding for all nutrition and attions were to provide the tube | | | The Director of Nursing/design will present a summary of the | nee | |
| | - | an's order and to monitor tube | | | audits to the Quality Assurance | re | |
| | feeding tolerance. | and sorder and to monitor tube | | | committee monthly for 6 mont Thereafter, if determined by the | hs. | |
| | A Physician's Orde | er, dated 2/2/24, indicated the | | | Quality Assurance committee | | |
| | | ing by mouth (NPO) diet. | | | auditing and monitoring will be | | |
| | A Dharainianta and a | | | | done quarterly and present | | |
| | - | r, dated 2/4/24, indicated to effecting by pump via peg tube | | | quarterly at the QA meeting. | | |
| | | time at 10:00 a.m., and off time | | | Monitoring will be on going. Date by which systemic | | |
| | at 6:00 a.m. | time at 10.00 a.m., and off time | | | corrections will be completed: | | |
| | at 0.00 a.m. | | | | 11/8/2024 | | |
| | The Medication Ad | dministration Record (MAR), | | | | | |
| | dated 10/2024, indi | icated the tube feeding was | | | | | |
| | signed out as turned | d off at 6:00 a.m. on 10/18/24. | | | | | |
| | | w on 10/18/24 at 3:03 p.m., the | | | | | |
| | | g (DON) indicated she | | | | | |
| | | e feeding concern and had no | | | | | |
| | additional informat | tion to add. | | | | | |
| | 3.1-44(a)(2) | | | | | | |
| F 0695 | 483.25(i) | | | | | | |
| SS=D | Respiratory/Trach | neostomy Care and | | | | | |
| Bldg. 00 | Suctioning | | | | | | |
| | | on, record review, and | F 06 | 95 | Munster Med INN | | 11/08/2024 |
| | | ity failed to ensure oxygen was | | | Annual Survey: 10/22/2024 | | |
| | | rate for 1 of 1 resident reviewed | | | Please accept the following as | | |
| | for oxygen. (Reside | ent 120) | | | facility's credible allegation of compliance. This plan of | | |
| | Finding includes: | | | | correction does not constitute admission of guilt or liability by | | |
| | On 10/15/24 at 10:: | 34 a.m. and 3:11 p.m., Resident | | | facility and is submitted only in | - | |
| | | in his room in bed with oxygen | | | response to the regulatory | | |

| STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA | | (X2) MULTIPLE CONSTRUCTION | | | (X3) DATE SURVEY | | |
|--|--|------------------------------------|-------|----------|--|----------|------------|
| AND PLAN | OF CORRECTION | IDENTIFICATION NUMBER | A. BU | JILDING | 00 | COMPL | ETED |
| | | 155131 | B. W | ING | | 10/22 | 2024 |
| | | | | STREET | ADDRESS, CITY, STATE, ZIP COD | <u> </u> | |
| NAME OF F | PROVIDER OR SUPPLIEF | 8 | | | ALUMET AVE | | |
| MIINIQTE | R MED-INN | | | | ER, IN 46321 | | |
| IVIOINGIE | | | | IVIOINST | LIX, IIV 4002 I | | |
| (X4) ID | SUMMARY | 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 | | R LSC IDENTIFYING INFORMATION | | TAG | DEFICIENCY) | | DATE |
| | by the way of a nasal cannula in use. The oxygen | | | | requirement. | | |
| | concentrator was set at 3 liters. | | | | F695 Respiratory/Tracheostor | ny | |
| | | | | | Care and Suctioning | | |
| | On 10/16/24 at 11:18 a.m., the resident was | | | | What corrective action(s) will be | | |
| | observed in his room in bed. His oxygen was in | | | | accomplished for those reside | | |
| | | concentrator was set at 3 1/2 | | | found to have been affected b | y the | |
| | | , the oxygen concentrator was | | | deficient practice; | | |
| | set at below 4 liters | | | | R120's oxygen flow rate was | | |
| | | | | | corrected immediately. | | |
| | | 12 a.m., 11:35 a.m. and 2:14 p.m., | | | How the facility will identify oth | | |
| | | served in his room in bed. His | | | residents having the potential | | |
| | | and the oxygen concentrator | | | be affected by the same defici | | |
| | was set at 3 1/2 lite | rs. | | | practice and what corrective a | ction | |
| | | | | | will be taken; | | |
| | | dent 120 was reviewed on | | | All residents requiring oxygen | | |
| | | m. Diagnoses included, but | | | therapy have the potential to b | | |
| | | dementia with behavior | | | affected by the alleged deficie | nt | |
| | | otic disorder with delusions, | | | practice. | | |
| | | pulmonary disease (COPD), | | | What measures will be put into | | |
| | and oxygen depend | ent. | | | place or what systemic chang | | |
| | | | | | will be made to ensure that the | | |
| | | mum Data Set (MDS) | | | deficient practice does not rec | ur; | |
| | | /11/24, indicated the resident | | | Staff were educated on: | | |
| | | paired for daily decision making | | | · Providing oxygen at the orde | ered | |
| | · · | gen therapy while a resident | | | liter flow rate. | | |
| | of the facility. | | | | How the corrective action(s) w | | |
| | | 0/6/04 | | | monitored to ensure the defici | | |
| | | 2/6/24 and reviewed on | 1 | | practice will not recur, i.e., wh | | |
| | | the resident required oxygen | 1 | | quality assurance programs w | ıll be | |
| | | ongestive heart failure (CHF), | | | put into place; | | |
| | | t history of pneumonia. | | | Nursing Managers will audit 3 | | |
| | | led, but were not limited to, | 1 | | residents 2 times per week to | | |
| | oxygen via nasal cannula per physician's order. | | | | ensure oxygen is set at the | | |
| | A DI | | 1 | | ordered liter flow rate. | | |
| | A Physician's Order, dated 4/16/24 and listed as | | 1 | | Director of Nursing/designee | | |
| | current on the October 2024 Physician's Order | | | | present a summary of the aud | IITS | |
| | Summary (POS), indicated the resident was to | | | | to the Quality Assurance | | |
| | | xygen per nasal cannula | | | committee monthly for 6 mont | | |
| | continuously. | | | | Thereafter, if determined by th | | |
| | | | 1 | | Quality Assurance committee, | | l |

| STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA | | (X2) MULTIPLE CONSTRUCTION (X3) DATE SURV | | | SURVEY | | |
|--|-----------------------|---|-------------------|----------|---|----------|------------|
| AND PLAN (| OF CORRECTION | IDENTIFICATION NUMBER | A. Bl | UILDING | 00 | COMPLI | ETED |
| | | 155131 | B. W | ING | | 10/22/ | 2024 |
| | | | <u> </u> | STREET A | ADDRESS, CITY, STATE, ZIP COD | <u> </u> | |
| NAME OF P | ROVIDER OR SUPPLIER | L | | | ALUMET AVE | | |
| MUNSTE | R MED-INN | | MUNSTER, IN 46321 | | | | |
| (X4) ID | | STATEMENT OF DEFICIENCIE | | ID | PROVIDER'S PLAN OF CORRECTION | | (X5) |
| PREFIX | ` | CY MUST BE PRECEDED BY FULL | | PREFIX | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA | TE | COMPLETION |
| TAG | | LSC IDENTIFYING INFORMATION | _ | TAG | DEFICIENCY) | | DATE |
| | _ | on 10/18/24 at 11:14 a.m., the | | | auditing and monitoring will be |) | |
| | | of Nursing indicated he had | | | done quarterly and present | | |
| | _ | esident's oxygen daily and it | | | quarterly at the QA meeting. | | |
| | | nd he was wondering if maybe | | | Monitoring will be on going. | | |
| | the resident was adj | usting the flow rate. | | | Date by which systemic | | |
| | 2.1.47(.)(() | | | | corrections will be completed: | | |
| | 3.1-47(a)(6) | | | | 11/8/2024 | | |
| F 0805 | 483.60(d)(3) | | | | | | |
| SS=E | ` , ` , | leet Individual Needs | | | | | |
| Bldg. 00 | . 304 111 01111 10 10 | iost individual 140000 | | | | | |
| | Based on observation | on and interview, the facility | F 0 | 805 | Munster Med INN | | 11/08/2024 |
| | | repare a pureed (blended | | 002 | Annual Survey: 10/22/2024 | | 11,00,202. |
| | • • | ed to meet the needs of the | | | Please accept the following as | s the | |
| | , | the potential to affect 10 of 10 | | | facility's credible allegation of | | |
| | residents who receive | - | | | compliance. This plan of | | |
| | | • | | | correction does not constitute | an | |
| | Findings include: | | | | admission of guilt or liability by | | |
| | | | | | facility and is submitted only in | | |
| | 1. During the puree | d meal observation on 10/21/24 | | | response to the regulatory | | |
| | at 10:05 a.m., Dieta | ry Cook 1 was preparing to | | | requirement. | | |
| | make pureed bread | for the lunch meal. At that | | | F805 Food in Form to Meet | | |
| | time, there was no r | recipe in front of her to view. | | | Individual Needs | | |
| | She indicated she w | as making enough for 15 | | | What corrective action(s) will be | ре | |
| | pureed diets, howev | ver, there were only 10 | | | accomplished for those reside | nts | |
| | residents who had o | orders for a pureed meal. She | | | found to have been affected b | y the | |
| | removed 7 slices of | bread, broke them into little | | | deficient practice; | | |
| | | nem in the blender. She poured | | | Dietary manager immediately | | |
| | | ce carton into a measuring cup | | | corrected the staff to follow the | e | |
| | | about 4 ounces and | | | recipe for the puree bread and | t l | |
| | | t into the blender. She | | | chicken. | | |
| | | ore bread and milk for a total of | | | How the facility will identify oth | | |
| | | and 4 (8) ounce cartons of milk | | | residents having the potential | | |
| | _ | bread. The Food Service | | | be affected by the same defici | | |
| | | od by the cook during the | | | practice and what corrective a | ction | |
| | preparation. | | | | will be taken; | | |
| | | | | | All residents requiring puree d | | |
| | • • | ed bread, provided by the | | | have the potential to be affect | | |
| | FSM, indicated the | _ | | | by the alleged deficient practic | | |
| | 10 servings: 10 slice | es of bread, 3 cups of cold milk | | | What measures will be put into | o | |

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

2HNN11 Facility ID: 000056

If continuation sheet Page 39 of 49

| STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA | | (X2) MULTIPLE CONSTRUCTION | | | (X3) DATE SURVEY | | |
|--|---------------------|----------------------------------|-------------------|---------------------------|--|-----------|------------|
| AND PLAN | OF CORRECTION | IDENTIFICATION NUMBER | A. BUILDI | ING | 00 | COMPLETED | |
| | | 155131 | B. WING | | | 10/22/ | 2024 |
| | | | <u> </u> | _ | _ | | |
| NAME OF P | PROVIDER OR SUPPLIE | R | | | DDRESS, CITY, STATE, ZIP COD | | |
| | | | 7935 CALUMET AVE | | | | |
| MUNSTE | R MED-INN | | MUNSTER, IN 46321 | | | | |
| (X4) ID | SUMMARY | STATEMENT OF DEFICIENCIE | ID | ID MONUTERIOR IN AN OF GO | | | (X5) |
| PREFIX | (EACH DEFICIEN | NCY MUST BE PRECEDED BY FULL | PREI | FIX | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' | | COMPLETION |
| TAG | REGULATORY O | R LSC IDENTIFYING INFORMATION | TA | AG | DEFICIENCY) | 'E | DATE |
| | and 1/2 cup of mel | ted margarine. | | | place or what systemic change | es | |
| | 20 servings: 20 sli | ces of bread, 1 quart and 2 cups | | | will be made to ensure that the | | |
| | _ | of melted margarine. | | | deficient practice does not rec | | |
| | 1 | 2 | | | Dietary managers/dietary staff | | |
| | | | | | were re-educated on: | | |
| | 2. During the pure | ed observation on 10/21/24 at | | | · Following the recipes when | | |
| | | Cook 1 was preparing to make | | | preparing food including altere | ·d | |
| | | ken. The cook added 4 cups of | | | consistency diets | Ĭ | |
| | 1 ~ | of chicken base to a pan on the | | | How the corrective action(s) w | ill be | |
| | _ | ken broth. She scooped out the | | | monitored to ensure the deficie | | |
| | | en into a measuring cup and | | | practice will not recur, i.e., who | | |
| | | cup mark. She added the | | | quality assurance programs w | | |
| | | der and then added 4 cups of | | | put into place; | | |
| | | blended the mixture and | | | Dietary Manager/Designee wil | 1 | |
| | | n. There was no recipe in front | | | audit altered diets preparation | | |
| | _ | Food Service Manager stood | | | times per week to ensure the | _ | |
| | by the cook during | | | | recipe is followed and consiste | encv | |
| | , , | 1 1 | | | is accurate. | | |
| | The recipe for pure | eed baked chicken, provided by | | | Administrator/designee will | | |
| | the FSM, indicated | | | | present a summary of the aud | its | |
| | | ounds of diced chicken and 1 | | | to the Quality Assurance | | |
| | cup of chicken bro | | | | committee monthly for 6 month | ns. | |
| | | nds of diced chicken and 2 | | | Thereafter, if determined by th | | |
| | cups of chicken bro | | | | Quality Assurance committee, | | |
| | • | | | | auditing and monitoring will be | | |
| | During an interview | w on 10/21/24 at 4:40 p.m., the | | | done quarterly and present | | |
| | _ | cated the dietary cook was new, | | | quarterly at the QA meeting. | | |
| | | ry manager should have | | | Date by which systemic | | |
| | | ructed her to use the recipe. | | | corrections will be completed: | | |
| | | - | | | 11/8/2024 | | |
| | 3.1-21(a)(3) | | | | | | |
| | | | | | | | |
| F 0812 | 483.60(i)(1)(2) | | | | | | |
| SS=F | Food | | | | | | |
| Bldg. 00 | | re/Prepare/Serve-Sanitary | | | | | |
| | | on, record review, and | F 0812 | | Munster Med INN | | 11/08/2024 |
| | | ity failed to keep the kitchen | | | Annual Survey: 10/22/2024 | | |
| | 1 | repair related to dirty | | | Please accept the following as | the | |
| | | transportation carts, food | | | facility's credible allegation of | | |
| | preparation tables, | the steam table, and the reach | | | compliance. This plan of | | |

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

2HNN11 Facility ID: 000056

If continuation sheet Page 40 of 49

| STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA | | (X2) MULTIPLE CONSTRUCTION | | | (X3) DATE SURVEY | | |
|--|--|-----------------------------------|-----------|--------|---|----------|------------|
| AND PLAN | OF CORRECTION | IDENTIFICATION NUMBER | A. BUILDI | NG | 00 | COMPL | ETED |
| | | 155131 | B. WING | | | 10/22/ | /2024 |
| | | 1 | STI | REET A | ADDRESS, CITY, STATE, ZIP COD | <u> </u> | |
| NAME OF I | PROVIDER OR SUPPLIER | 8 | | | ALUMET AVE | | |
| MUNSTF | R MED-INN | | | | ER, IN 46321 | | |
| | Г | | | | | | Γ |
| (X4) ID | | STATEMENT OF DEFICIENCIE | ID | | PROVIDER'S PLAN OF CORRECTION | | (X5) |
| PREFIX | ` | CY MUST BE PRECEDED BY FULL | PREF | | (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY) | TE | COMPLETION |
| TAG | | R LSC IDENTIFYING INFORMATION | TA | .G | | | DATE |
| | | s stacking clean but wet plates | | | correction does not constitute | | |
| | | op of each other, and improper | | | admission of guilt or liability by | | |
| | glove usage while preparing ready to eat food for 1 of 1 kitchen. (The Main Kitchen) This had the | | | | facility and is submitted only in | 1 | |
| | potential to affect 154 of 155 residents who | | | | response to the regulatory | | |
| | 1 ~ | | | | requirement. | | |
| | resided in the facilit | ty. | | | F812 Food Procurement, | | |
| | Findings include: | | | | Store/Prepare/Serve/Sanitary | | |
| | rmanigs include: | | | | What corrective action(s) will be | | |
| | 1 During the Kita | hen Sanitation Tour on | | | accomplished for those reside found to have been affected b | | |
| | _ | n., with the Food Service | | | deficient practice; | y ii le | |
| | | | | | Liquid spills were cleaned fron | n | |
| | Manager (FSM) the following was observed: | | | | floors, doors, and walls. Burn | | |
| | a The sides doors | and inside of the convection | | | spillage, Grease and grim was | | |
| | | ith a large and heavy | | | cleaned from the food prepara | | |
| | | ease and burned food spillage | | | equipment including the | ition | |
| | on the bottom racks | | | | convection oven, transportation | 'n | |
| | | | | | carts, Food preparation tables | | |
| | b. There was a large | e scoop inside the sugar bin | | | steam table and reach in coole | | |
| | laying directly on the | - | | | 1,3 and 4. | 5.0 | |
| | | 5 | | | Scoop inside sugar bin was | | |
| | c. The sides of the f | food preparation table and the | | | removed bin was cleaned out | and | |
| | | rty with dried food spillage. | | | new sugar input. | | |
| | | | | | Plates and Dome lids dried be | fore | |
| | d. There were 5 ope | en transportation carts that | | | put away. | | |
| | | and dishes from the units. The | | | Proper glove usage while prep | paring | |
| | | l spillage all over the sides and | | | ready to eat food was complet | | |
| | racks. | | | | How the facility will identify oth | ner | |
| | | | | | residents having the potential | to | |
| | e. The freezer floor | and ceiling had a large amount | | | be affected by the same defici | | |
| | of ice build up with | large chunks observed. | | | practice and what corrective a | ction | |
| | | | | | will be taken. | | |
| | | 1, 3, and 4 were dirty on the | | | All residents have the potentia | | |
| | | vith dried food spillage. The | | | be affected by the alleged defi | cient | |
| | vent inside the coolers were dusty and dirty. | | | | practice. | | |
| | | | | | What measures will be put into |) | |
| | During an interview on 10/15/24 at 10:15 a.m., the | | | | place or what systemic change | es | |
| | | of the above was in need of | | | will be made to ensure that the | | |
| | cleaning. | | | | deficient practice does not rec | ur. | |
| | | | | | Dietary manager/dietary staff | were | |

| STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA | | X1) PROVIDER/SUPPLIER/CLIA | (X2) MULTIPLE CONSTRUCTION | | | (X3) DATE SURVEY | |
|--|---|---|----------------------------|----------|---|------------------|------------|
| AND PLAN | OF CORRECTION | IDENTIFICATION NUMBER | A. BU | ILDING | 00 | COMPL | |
| | | 155131 | B. WI | NG | _ | 10/22/ | 2024 |
| | | | <u> </u> | STREET A | ADDRESS, CITY, STATE, ZIP COD | | |
| NAME OF F | PROVIDER OR SUPPLIEF | 8 | | | ALUMET AVE | | |
| MUNSTE | R MED-INN | | | | TER, IN 46321 | | |
| (X4) ID | SUMMARY | STATEMENT OF DEFICIENCIE | | ID | DECUIDED ON AN OF CODDECTION | | (X5) |
| PREFIX | (EACH DEFICIEN | CY MUST BE PRECEDED BY FULL | 1 | PREFIX | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA | тс | COMPLETION |
| TAG | REGULATORY OF | LSC IDENTIFYING INFORMATION | | TAG | DEFICIENCY) | .16 | DATE |
| | During an interview | on 10/22/24 at 11:15 a.m., the | | | re-educated on: | | |
| | Maintenance Director indicated the ice build up | | | | Keeping Kitchen clean of del | bris | |
| | was probably from the plastic strips getting | | | | such as liquid spills, splashes, | , | |
| | caught in the door or from staff not shutting the | | grease and grim build up. | | | | |
| | door all the way. | | | | Keeping convection oven/oven/oven/oven/oven/oven/oven/oven/ | ens | |
| | | | | | clean | | |
| | | | | | Cleaning Transportation cart | s, | |
| | | d food prep observation on | | | food preparation tables, steam | | |
| | | .m., Dietary Cook 1 was | | | table, and the reach in coolers | | |
| | | er hands with soap and water | | | Keeping Kitchen floors, walls | | |
| | | elean pair of gloves to both | | | freezer and behind equipment | | |
| | | oved hands, she opened the | | | clean. | | |
| | | oved the lid from the blender | | | • Dishes dried before being pu | ıt | |
| | _ | ns of milk. She then removed | | | away. | | |
| | | wrapper with the same gloved | | | Kitchen sanitation | | |
| | | art and placed it inside the | | | Proper drying of dishes before | re | |
| | _ | e lid back on the blender with | | | being stored | | |
| | _ | nds and added milk to the | | | Proper glove usage while | | |
| | _ | ed these steps using the same | | | preparing ready to eat food | | |
| | | g the entire pureed bread | | | How the corrective action(s) w | | |
| | | SM stood by the cook and | | | monitored to ensure the defici | | |
| | observed the entire | procedure. | | | practice will not recur, i.e., who | | |
| | Daning on internal | 10/21/24 - 4 10:25 | | | quality assurance programs w | ill be | |
| | _ | y on 10/21/24 at 10:25 a.m., | | | put into place; | الم، | |
| | 1 | icated she was unaware she er items with her gloved | | | Administrator/Designee will au | iuit | |
| | hands and then touch | | | | kitchen 2 times per week to ensure cleanliness/sanitation | of | |
| | nanus and men touc | n the oreau. | | | the kitchen areas is maintaine | | |
| | | | | | Administrator/designee will | u. | |
| | 3 During a randor | n observation on 10/21/24 at | | | present a summary of the aud | ite | |
| | _ | Aide 1 was observed stacking | | | to the Quality Assurance | າເວ | |
| | - | s, dome lids and trays on top of | | | committee monthly for 6 mont | he | |
| | | exited the dish machine. | | | Thereafter, if determined by the | | |
| | caon omer as mey c | Artes are dish machine. | | | Quality Assurance committee, | | |
| | During an interview | with the FSM at the time of | | | auditing and monitoring will be | | |
| | During an interview with the FSM at the time of the observation, she indicated the plates and | | | | done quarterly and present | , | |
| | dome lids should not be stacked on top of each | | | | quarterly at the QA meeting. [|)ate | |
| | | ructed the dietary aide not to | | | by which systemic corrections | | |
| | stack them. | racted the dictary and not to | | | be completed: 11/8/2024 | v ∜ 111 | |
| | Sack menn. | | | | 50 00mpictod. 11/0/2024 | | |

| STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155131 | | (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY A. BUILDING 00 COMPLETED B. WING 10/22/2024 | | | | | |
|--|---|---|---|---|---------------------------|--|--|
| | PROVIDER OR SUPPLIER | | STREET ADDRESS, CITY, STATE, ZIP COD 7935 CALUMET AVE MUNSTER, IN 46321 | | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIEN | STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL . LSC IDENTIFYING INFORMATION | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY) | (X5) COMPLETION DATE | | |
| F 0842 SS=D Bldg. 00 | Administrator indice was in need of clear dietary cook was need have intervened and gloves. The current 9/2020 Sanitation" policy, pon 10/22/24 at 10:00 wash hands and arm water and after hand food and before hand Staff would avoid comilk, water, soup, be sandwiches, salads, would not be process 3.1-21(i)(3) 483.20(f)(5), 483.7 Resident Records Based on record reversal failed to ensure clin accurately document orders for 1 of 6 resunnecessary medical reviewed for tube for 113) Findings include: 1. The record for Resident Records are were not limited to, hypertension, and do The Quarterly Minimage of the same process. | ro(i)(1)-(5) - Identifiable Information riew and interview, the facility ical records were complete and ited related to medication idents reviewed for itions and 1 of 1 resident reding. (Residents 139 and resident 139 was reviewed on in. Diagnoses included, but type 2 diabetes mellitus, | F 0842 | Munster Med INN Annual Survey: 10/22/2024 Please accept the following as facility's credible allegation of compliance. This plan of correction does not constitute admission of guilt or liability by facility and is submitted only in response to the regulatory requirement. F842 Resident Records-Identifiable Information What corrective action(s) will accomplished for those reside found to have been affected by deficient practice; R113's medication route orde | an y the n be ents by the | | |

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

2HNN11 Facility ID: 000056

If continuation sheet

Page 43 of 49

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 10/22/2024 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 was mildly cognitively impaired and received were updated. anti-anxiety and antipsychotic medications. R139's Medication strength and dose were clarified and updated. A Physician's Order, dated 4/2/24, indicated the How the facility will identify other resident was to receive ABH residents having the potential to (Ativan/Benadryl/Haldol) gel (a hospice be affected by the same deficient medication for agitation) to the wrist topically two practice and what corrective action times a day for agitation and aggressive behavior. will be taken; All residents have the potential to There was no documented strength, dosage, or amount to give listed in the medication order. be affected by this alleged deficient practice. The Medication Administration Record (MAR), What measures will be put into dated 10/2024, indicated the resident had received place or what systemic changes the ABH gel medication twice a day. There was a will be made to ensure that the lack of any documentation of the strength, deficient practice does not recur; dosage, or amount given. Nursing staff were educated on: · Ensuring medications routes are accurate (oral, g-tube, topical, During an interview on 10/21/24 at 4:41 p.m., the Director of Nursing (DON) indicated the label on sublingual, etc.) the ABH gel medication listed the strength, · Medication orders have what dosage, and amount to give. The staff had been dose/strength is to be administering it correctly. She indicated she administered in the order. would update the Physician's Order in the How the corrective action(s) will be computer. monitored to ensure the deficient 2. The record for Resident 113 was reviewed on practice will not recur, i.e., what 10/18/24 at 10:00 a.m. Diagnoses included, but quality assurance programs will be were not limited to, hemiplegia (paralysis on one put into place; side of the body), stroke, depression, dementia, DON/designee will audit 5 anxiety, dysphagia (difficulty swallowing), and residents' medication with special diabetes. focus on complete medication orders including administration The Quarterly Minimum Data Set (MDS) route and strength/dosage to be assessment, dated 7/29/24, indicated the resident administered 2 times per week to was severely impaired for daily decision making ensure compliance. and had a feeding tube. DON/designee will present a summary of the audits to the A Care Plan, dated 7/29/24, indicated the resident Quality Assurance committee was at risk for malnutrition (poor nutrition) and monthly for 6 months. Thereafter, was reliant on a tube feeding for all nutrition and if determined by the Quality

hydration. Interventions were to provide the tube

Assurance committee, auditing

| STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA | | (X2) MULTIPLE CONSTRUCTION | | | (X3) DATE SURVEY | | |
|--|------------------------|-----------------------------------|---------------------------|--------|--|----------|------------|
| AND PLAN | OF CORRECTION | IDENTIFICATION NUMBER | A. BUILDIN | ١G | 00 | COMPL | ETED |
| | | 155131 | B. WING | | | 10/22/ | 2024 |
| | | | CTP | LEET A | DDDEGG CITY CTATE TIP COD | <u> </u> | |
| NAME OF P | ROVIDER OR SUPPLIER | 1 | | | DDRESS, CITY, STATE, ZIP COD | | |
| MUNICEE | D MED ININ | | | | ALUMET AVE | | |
| MUNSIE | R MED-INN | | MC | JNST | ER, IN 46321 | | |
| (X4) ID | SUMMARY | STATEMENT OF DEFICIENCIE | ID PROVIDER'S BLANCE CORR | | PROVIDER'S PLAN OF CORRECTION | (X5) | |
| PREFIX | (EACH DEFICIEN | CY MUST BE PRECEDED BY FULL | PREF | IX | (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA | TE | COMPLETION |
| TAG | REGULATORY OR | LSC IDENTIFYING INFORMATION | TAG | G | DEFICIENCY) | | DATE |
| | feeding per physicia | an's order and monitor the tube | | | and monitoring will be done | | |
| | feeding tolerance. | | | | quarterly and present quarterly | √at | |
| | _ | | | | the QA meeting. Monitoring wi | | |
| | A Physician's Order | r, dated 2/2/24, indicated the | | | on going. | | |
| | resident had a nothi | ng by mouth (NPO) diet. | | | Date by which systemic | | |
| | | | | | corrections will be completed: | | |
| | A Physician's Order | r, dated 5/14/24, indicated to | | | 11/8/2024 | | |
| | - | an anti-anxiety medication) oral | | | | | |
| | tablet 0.25 milligran | m (mg) by mouth at bedtime. | | | | | |
| | | | | | | | |
| | A Physician's Order | r, dated 5/14/24, indicated to | | | | | |
| | administer Norco (p | pain pill) an oral tablet 5-325 | | | | | |
| | milligram (mg) by 1 | mouth every 12 hours as needed | | | | | |
| | for pain. | | | | | | |
| | | | | | | | |
| | The Medication Ad | ministration Record (MAR), | | | | | |
| | indicated the oral N | orco was signed out as given | | | | | |
| | on 6/2/24, 6/8/24, 6 | /19/24 and 9/17/24. The oral | | | | | |
| | Xanax was signed of | out as given by mouth from | | | | | |
| | May 2024 through | October 2024. | | | | | |
| | | | | | | | |
| | _ | on 10/18/24 at 3:03 p.m., the | | | | | |
| | _ | indicated the orders would be | | | | | |
| | changed to reflect the | he resident's NPO status | | | | | |
| | | | | | | | |
| | 3.1-50(a)(2) | | | | | | |
| | | | | | | | |
| F 0921 | 483.90(i) | | | | | | |
| SS=E | Safe/Functional/S | anitary/Comfortable Environ | | | | | |
| Bldg. 00 | | | | | | | |
| | | on and interview, the facility | F 0921 | | Munster Med-Inn | | 11/08/2024 |
| | • | esidents' environment clean | | | Annual Survey: 10/22/2024 | | |
| | | related to dirty floors, toilets, | | | Please accept the following as | the | |
| | walls, tube feeding | | | | facility's credible allegation of | | |
| | | e cans, and debris in light | | | compliance. This plan of | | |
| | | y also failed to keep the kitchen | | | correction does not constitute | | |
| | | d splattered on walls, dirty | | | admission of guilt or liability by | | |
| | | oing under the dish machine for | | | facility and is submitted only in | 1 | |
| | | of 1 kitchens. (The 2nd, 3rd, | | | response to the regulatory | | |
| | 4th, 5th floors, and | the main kitchen) | | | requirement. | | |

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

2HNN11 Facility ID: 000056

If continuation sheet Page 45 of 49

| A. BULINS DO DENTIFICATION NUMBER 155131 NAME OF PROVIDER OR SUPPLIER 155131 NAME OF PROVIDER OR SUPPLIER OR SUP | STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA | | (X2) MULTIPLE CONSTRUCTION | | | (X3) DATE SURVEY | | |
|--|--|---|---------------------------------|-------|---------|---|-------|------------|
| MUNSTER MED-INN (X4) ID PREFIX TAG SUMMARY STATEMENT OF DEFICIENCIE PREFIX TAG Findings include: 1. During a random observation on 10/15/24 at 11:27 a.m., there were 4 residents who shared the bathroom. 3. During an interview on 10/16/24 at 11:41 a.m., room 209 was observed with dried bowel movement on the raised tollet seat and the tollet bow had just been cleaned by the back of the toilet own, had finded bowel movement on the raised tollet seat and the bathroom. During an interview on 10/16/24 at 11:55 a.m., the Director of Housekeeping from a sister facility indicated the toilet and bathroom was dirry. 4. During an interview on 10/16/24 at 2:29 p.m., a family member indicated the floors were a direct own and dirty. The resident tresided on the 2nd floor. During an interview on 10/16/24 at 2:29 p.m., a family member indicated the foors were a direct own and dirty. The resident resided on the 2nd floor. During an interview on 10/16/24 at 2:29 p.m., a family member indicated the foors were sticky and dirty. The resident resided on the 2nd floor. A During an interview on 10/16/24 at 2:29 p.m., a family member indicated the floors were sticky and dirty. The resident resided on the 2nd floor. A During an interview on 10/16/24 at 2:29 p.m., a family member indicated the floors were sticky and dirty. The resident resided on the 2nd floor. A During an interview on 10/16/24 at 2:29 p.m., a family member indicated the floors were sticky and dirty. The resident resided on the 2nd floor. | AND PLAN | OF CORRECTION | IDENTIFICATION NUMBER | A. BU | JILDING | 00 | COMPL | ETED |
| MUNSTER MED-INN (X9) D SUMMARY STATEMENT OF DEFICIENCY TAG REGULATORY OR LSC IDENTIFYING INFORMATION Findings include: Incomparison on 10/15/24 at 11/27 a.m., there was an overflowing garbage can that contained personal protective equipment in room 229, Yellow isolation gowns and gloves were observed on the floor. There was I resident who resided in the room. 2. During an interview on 10/15/24 at 24/8 p.m., a family member indicated the room always smelled like urine and the floors were so dirty they have cleaned it themselves. They have noticed housekeeping did not clean the room every day. The resident resided on the 2nd floor. The back of the toilet, where the grab barn were nailed down, had dried bowel movement and urine as well as a pink substance. The ceiling vent was dirty and dusty. There were 4 residents who shared the bathroom. A. During an interview on 10/16/24 at 11:55 a.m., the Director of Housekeeping from a sister facility indicated the toilet and bathroom was dirty. 4. During an interview on 10/16/24 at 2:29 p.m., a family member indicated the floors were sticky and dirty. The resident resided on the 2nd floor. PREFIX TAG Direction PROFINATION PREFIX TAG DIRECTION TAGE PREFIX TAG DIRECTION TAGE COMMENTAL TOWN COMPLETION DATE PREFIX TAGE PREFIX TAGE PROFINE TAGE COMMENTAL TOWN COMPLETION DATE PREFIX TAGE PROFINE TAGE COMMENTAL TOWN COMPLETION DATE PREFIX TAGE COMMENTAL TOWN COMPLETION DATE PREFIX TAGE COMMENTAL TAGE COMPLETION COMPLETION DATE PREFIX TAGE COMPLETION COMPLETION DATE PREFIX TAGE COMPLETION COMPLETION COMPLETION DATE PREFIX TAGE COMPLETION COMPLETION COMPLETION DATE PREFIX TAGE COMPLETION COMPLETION COMPLETION COMPLETION COMPLETION DATE PREFIX TAGE COMPLETION DATE PREFIX TAGE COMPLETION | | | 155131 | B. W | ING _ | | 10/22 | /2024 |
| MUNSTER MED-INN (X9) D SUMMARY STATEMENT OF DEFICIENCY TAG REGULATORY OR LSC IDENTIFYING INFORMATION Findings include: Incomparison on 10/15/24 at 11/27 a.m., there was an overflowing garbage can that contained personal protective equipment in room 229, Yellow isolation gowns and gloves were observed on the floor. There was I resident who resided in the room. 2. During an interview on 10/15/24 at 24/8 p.m., a family member indicated the room always smelled like urine and the floors were so dirty they have cleaned it themselves. They have noticed housekeeping did not clean the room every day. The resident resided on the 2nd floor. The back of the toilet, where the grab barn were nailed down, had dried bowel movement and urine as well as a pink substance. The ceiling vent was dirty and dusty. There were 4 residents who shared the bathroom. A. During an interview on 10/16/24 at 11:55 a.m., the Director of Housekeeping from a sister facility indicated the toilet and bathroom was dirty. 4. During an interview on 10/16/24 at 2:29 p.m., a family member indicated the floors were sticky and dirty. The resident resided on the 2nd floor. PREFIX TAG Direction PROFINATION PREFIX TAG DIRECTION TAGE PREFIX TAG DIRECTION TAGE COMMENTAL TOWN COMPLETION DATE PREFIX TAGE PREFIX TAGE PROFINE TAGE COMMENTAL TOWN COMPLETION DATE PREFIX TAGE PROFINE TAGE COMMENTAL TOWN COMPLETION DATE PREFIX TAGE COMMENTAL TOWN COMPLETION DATE PREFIX TAGE COMMENTAL TAGE COMPLETION COMPLETION DATE PREFIX TAGE COMPLETION COMPLETION DATE PREFIX TAGE COMPLETION COMPLETION COMPLETION DATE PREFIX TAGE COMPLETION COMPLETION COMPLETION DATE PREFIX TAGE COMPLETION COMPLETION COMPLETION COMPLETION COMPLETION DATE PREFIX TAGE COMPLETION DATE PREFIX TAGE COMPLETION | | | | | STREET | ADDRESS CITY STATE ZIP COD | | |
| MUNSTER, IN 46321 CACH DEFICENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION PREFIX TAG PROGRAM-SERBRICATE OF THE APPROPRIATE | NAME OF P | PROVIDER OR SUPPLIEF | ₹ | | | | | |
| SUMMARY STATEMENT OF DEFICIENCIE TAG SUMMARY STATEMENT OF DEFICIENCIE TAG SUMMARY STATEMENT OF DEFICIENCY MUST BE PERCEIDED BY BUILT. TAG SUMMARY STATEMENT BY BUILT. TAG SUMMARY STATEM | MUNSTE | R MED-INN | | | | | | |
| PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION Findings include: 1. During a random observation on 10/15/24 at 11:27 a.m., there was an overflowing garbage can that contained personal protective equipment in room 229. Yellow isolation gowns and gloves were observed on the floor. There was 1 resident who resided in the room. 2. During an interview on 10/15/24 at 2:48 p.m., a family member indicated the room always smelled like urine and the floors were so dirty they have cleaned it themselves. They have noticed housekeeping dirth of the clean the room every day. The resident resided on the 2nd floor. 3. During an observation on 10/16/24 at 11:41 a.m., room 209 was observed with dried bowel movement on the raised toilet seat and the toilet bowl had just been eleaned by the housekeeper. The back of the toilet, where the grab bars were nailed down, had dried bowel movement and urine as well as a pink substance. The celling vent was dirty and dusty. There were 4 residents who shared the buthroom. During an interview on 10/16/24 at 11:55 a.m., the Director of Housekeeping from a sister facility indicated the toilet and bathroom was dirty. 4. During an interview on 10/16/24 at 2:29 p.m., a family member indicated the floors were sticky and dirty. The resident resided on the 2nd floor. PREFIX TAG F321 Sate/Functional/Sanitary/ Confortable Environment What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice: Housekeeping was informed and has completed the cleaning needs for the listed rooms: 513,517,519,502,504,514,209,215, 223,229,209,212,214,216,229,327, and 421 including main entrance on floors 2,34, and 5. Housekeeping was also notified and has completed the cleaning needs for bathrooms, dirty floors, dirty floors, dirty floors, walls, tube feeding poles, Ceiling vents, over bedtables, overflowing garbage cans, debris in light fixtures. Maintenance was informed and has completed the needed repairs in rooms: 513,517,215,214, and 216 includ | WONOTE | | | | WIONO | | | |
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| room 209 was observed with dried bowel movement on the raised toilet seat and the toilet bowl had just been cleaned by the housekeeper. The back of the toilet, where the grab bars were nailed down, had dried bowel movement and urine as well as a pink substance. The ceiling vent was dirty and dusty. There were 4 residents who shared the bathroom. During an interview on 10/16/24 at 11:55 a.m., the Director of Housekeeping from a sister facility indicated the toilet and bathroom was dirty. 4. During an interview on 10/16/24 at 2:29 p.m., a family member indicated the floors were sticky and dirty. The resident resided on the 2nd floor. Fixtures. Maintenance was informed and has completed the needed repairs in rooms: 513,517,215,214, and 216 including scratched wall, marred walls, dirty light fixture, gouged door, headboards 517 paint peeled above heating unit repaired. 215 door frame was fixed. Resident toiletries were stored appropriately and contained in 514, 518, 519 bathrooms. Food splatters on kitchen walls, dirty floors and dirty piping under dish machine corrected. Rubber board on the back splash also repaired. How the facility will identify other | | 1 D : 1 | . 10/16/04 . 11 41 | | | | wing | |
| movement on the raised toilet seat and the toilet bowl had just been cleaned by the housekeeper. The back of the toilet, where the grab bars were nailed down, had dried bowel movement and urine as well as a pink substance. The ceiling vent was dirty and dusty. There were 4 residents who shared the bathroom. During an interview on 10/16/24 at 11:55 a.m., the Director of Housekeeping from a sister facility indicated the toilet and bathroom was dirty. 4. During an interview on 10/16/24 at 2:29 p.m., a family member indicated the floors were sticky and dirty. The resident resided on the 2nd floor. Maintenance was informed and has completed the needed repairs in rooms: 513,517,215,214, and 216 including scratched wall, marred walls, dirty light fixture, gouged door, headboards 517 paint peeled above heating unit repaired. 215 door frame was fixed. Resident toiletries were stored appropriately and contained in 514, 518, 519 bathrooms. Food splatters on kitchen walls, dirty floors and dirty piping under dish machine corrected. Rubber board on the back splash also repaired. How the facility will identify other | | - | | | | 1 | | |
| bowl had just been cleaned by the housekeeper. The back of the toilet, where the grab bars were nailed down, had dried bowel movement and urine as well as a pink substance. The ceiling vent was dirty and dusty. There were 4 residents who shared the bathroom. During an interview on 10/16/24 at 11:55 a.m., the Director of Housekeeping from a sister facility indicated the toilet and bathroom was dirty. 4. During an interview on 10/16/24 at 2:29 p.m., a family member indicated the floors were sticky and dirty. The resident resided on the 2nd floor. base completed the needed repairs in rooms: 513,517,215,214, and 216 including scratched wall, marred walls, dirty light fixture, gouged door, headboards 517 paint peeled above heating unit repaired. 215 door frame was fixed. Resident toiletries were stored appropriately and contained in 514, 518, 519 bathrooms. Food splatters on kitchen walls, dirty floors and dirty piping under dish machine corrected. Rubber board on the back splash also repaired. How the facility will identify other | | | | | | | | |
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| indicated the toilet and bathroom was dirty. appropriately and contained in 514, 518, 519 bathrooms. Food splatters on kitchen walls, dirty floors and dirty piping under dish machine corrected. Rubber board on the back splash also repaired. How the facility will identify other | | | | | | | 4 | |
| 514, 518, 519 bathrooms. Food splatters on kitchen walls, dirty floors and dirty piping under dirty. The resident resided on the 2nd floor. 514, 518, 519 bathrooms. Food splatters on kitchen walls, dirty floors and dirty piping under dish machine corrected. Rubber board on the back splash also repaired. How the facility will identify other | | | | | | | | |
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| 4. During an interview on 10/16/24 at 2:29 p.m., a family member indicated the floors were sticky and dirty. The resident resided on the 2nd floor. dirty. The resident resided on the 2nd floor. dirty. The resident resided on the 2nd floor. dirty floors and dirty piping under dish machine corrected. Rubber board on the back splash also repaired. How the facility will identify other | | | | | | | 9 | |
| family member indicated the floors were sticky and dish machine corrected. Rubber board on the back splash also repaired. How the facility will identify other | | 4 During an interview on 10/16/24 at 2:29 n m a | | | | 1 · · · · · · · · · · · · · · · · · · · | | |
| dirty. The resident resided on the 2nd floor. board on the back splash also repaired. How the facility will identify other | | | | | | | | |
| repaired. How the facility will identify other | | | | | | | | |
| How the facility will identify other | | dirty. The resident resided on the 2nd floor. | | | | · · · · · · · · · · · · · · · · · · · | • | |
| | | | | | | 1 · · · · · · | ner | |
| | | 5. During the Envir | conmental Tour on 10/22/24 at | | | residents having the potential | | |

| STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA | | (X2) MULTIPLE CONSTRUCTION (X3) DATE SUF | | | SURVEY | | |
|--|---|--|---------------------------------|------------------------------------|--|--------|------------|
| AND PLAN | OF CORRECTION | IDENTIFICATION NUMBER | A. BU | UILDING | 00 | COMPL | ETED |
| | | 155131 | B. W | ING | | 10/22/ | 2024 |
| | | l . | | CTREET | ADDRESS, CITY, STATE, ZIP COD | | |
| NAME OF P | ROVIDER OR SUPPLIER | ₹ | | | ALUMET AVE | | |
| MUNICEE | R MED-INN | | | | | | |
| MONSIE | R MED-INN | | | MONSI | ΓER, 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 | TE | COMPLETION |
| TAG | REGULATORY OF | R LSC IDENTIFYING INFORMATION | | TAG | DEFICIENCY) | | DATE |
| | 10:30 a.m., with the | e Director of Maintenance, the | | | be affected by the same defici | ent | |
| | Administrator, and | the Director of Housekeeping | | | practice and what corrective a | ction | |
| | the following was o | bserved: | | | will be taken. | | |
| | | | | All residents of the facility have | | | |
| | a. 2nd Floor | | | | the potential to be affected by | the | |
| | | | | | same alleged deficient practic | e. | |
| | | er bed table and the tube | | | What measures will be put into | o | |
| | feeding pole had dr | ied enteral feeding on the | | | place or what systemic change | | |
| | base. The | | | | will be made to ensure that the | | |
| | _ | e and bed was dirty with dried | | | deficient practice does not rec | ur: | |
| | | e. The wall by the heat register | | | Staff were educated on: | | |
| | | nd the heat register was dirty. | | | ü Notifying environmental serv | /ice | |
| | The floor mats were | e observed with dried food | | | and maintenance of any need | ed | |
| | | eding and they were torn and | | | repairs and cleaning needs. | | |
| | - | loor in the room was dirty with | | | ü Floor, vents, and residents r | oom | |
| | black marks and sta | ins. The hot water faucet was | | | cleaned daily | | |
| | | a trickle and not a full stream. | | | ü Keeping resident's toiletry ite | ems | |
| | | ld up around the faucets. The | | | contained/stored properly | | |
| | | l like stale urine. There were 2 | | | ü Keeping kitchen cleaned | | |
| | | ed in the room and 4 shared | | | How the corrective action(s) w | | |
| | the bathroom. | | | | monitored to ensure the defici | ent | |
| | | | | | practice will not recur, i.e., who | at | |
| | - Room 215: the roo | om door frame was gouged. | | | quality assurance programs w | ill be | |
| | | | | | put into place. | | |
| | | was debris in the bathroom light | | | The housekeeping Director wi | | |
| | | 4 residents who shared the | | | audit 5 rooms and 4 hallways | per | |
| | bathroom. | | | | week on alternating units for | | |
| | | | | | Cleanliness. | | |
| | | or was dirty with black scuff | | | The Maintenance Director will | | |
| | | here was adhered dirty in the | | | audit 5 rooms per week on | | |
| | _ | he baseboard. The back of the | | | alternating units for maintenar | nce | |
| | _ | b bars were nailed down had | | | issues. Any issues will be | | |
| | | d a dried pink substance. There | | | corrected. | | |
| | | resided in the room and 3 | | | Facility Angel's will audit 10 | | |
| | residents shared the | bathroom. | | | resident rooms 3 times per we | ek | |
| | | | | | to ensure personal items are | | |
| | - Room 229: the floor was dirty with stains and | | contained/stored properly. | | | | |
| | | There was 1 resident who | The Administrator/designee will | | | | |
| | resided in the room | | | | present a summary of the aud | its | |
| | | | 1 | | to the Quality Assurance | | |

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

2HNN11 Facility ID: 000056

If continuation sheet Page 47 of 49

| STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155131 | | ľ í | UILDING | instruction 00 | (X3) DATE (COMPL 10/22/ | ETED | | |
|--|--|---|---|---------------------|---|----------|----------------------------|--|
| | PROVIDER OR SUPPLIEI ER MED-INN | R | STREET ADDRESS, CITY, STATE, ZIP COD 7935 CALUMET AVE MUNSTER, 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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY) | TE | (X5) COMPLETION DATE | |
| TAG | b. 3rd Floor Room 327: the badried enteral feeding also had dried tube c. 4th Floor Room 421: the floor fl | or was sticky throughout the garbage under both beds. I on both halls and dining room and dirty. oth halls was marred with black was a urine odor in the ere 2 residents who used the adboard was loose and the wall gouged with holes. The floor dirty. There was a urine odor was an uncontained tooth and an emesis basin on top of 4 residents who shared the was paint peeling above the was 1 resident who resided in was strong urine odor in the oilet lift seat was discolored | | TAG | committee monthly for 6 month. 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: 11/8/2024 | ns. e | DATE | |
| | yellow. There was | an uncontained gray wash | | | | | | |

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

2HNN11 Facility ID: 000056

If continuation sheet

Page 48 of 49

| AND PLAN OF CORRECTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155131 | | (X2) MULTIPLE A. BUILDING B. WING | O0 | COM | E SURVEY PLETED 2/2024 | | | |
|---|--|--|---|---|------------------------------|------------|--|--|
| | PROVIDER OR SUPPLIE | 3 | STREET ADDRESS, CITY, STATE, ZIP COD 7935 CALUMET AVE MUNSTER, IN 46321 | | | | | |
| (X4) ID | SUMMARY | STATEMENT OF DEFICIENCIE | ID | PROVIDER'S PLAN OF CORREC | TION | (X5) | | |
| PREFIX | * | ICY MUST BE PRECEDED BY FULL | PREFIX | (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APP | LD BE | COMPLETION | | |
| TAG | | R LSC IDENTIFYING INFORMATION | TAG | DEFICIENCY) | | DATE | | |
| | basin on the floor u 4 residents who sha | anderneath the sink. There were ared the bathroom. | | | | | | |
| | _ | nen Sanitation Tour on 10/15/24 ne Food Service Manager (FSM) observed: | | | | | | |
| | preparation equipm including the dish r | n floor, behind all of the food tent and under all of the tables, machine area was dirty with food substances and black | | | | | | |
| | with dried food spil substances. The wh machine had a heav spillage and dirt. The | If the dish machine were dirty blage and a black and orange wite pvc pipes under the dish by accumulation of dried food the black rubber board on the black rubber board on the black rubber board wall. | | | | | | |
| | | iling throughout the kitchen dried food spillage. | | | | | | |
| | | ling light covers that were dirty llage and/or debris on the | | | | | | |
| | | dried food storage room had a n of food debris, crumbs, and | | | | | | |
| | | v on 10/15/24 at 10:15 a.m., the of the above was in need of | | | | | | |
| | This citation relates to Complaint IN00445179. | | | | | | | |
| | 3.1-19(f) | | | | | | | |

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Event ID:

2HNN11 Facility ID: 000056

If continuation sheet Page 49 of 49