STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155131	A. BUILDING 00 B. WING	10/22/2024

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

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F 0000 Bldg. 00	This visit was for a Recertification and State Licensure Survey. This visit included the Investigation of Complaints IN00444806, IN00444914, and IN00445179. Complaint IN00444806 - Federal/state deficiencies related to the allegations are cited at F689. Complaint IN00444914 - Federal/state deficiencies related to the allegations are cited at F689. Complaint IN00445179 - Federal/state deficiencies related to the allegations are cited at F689 and F921. Survey dates: October 15, 16, 17, 18, 21, and 22, 2024 Facility number: 000056 Provider number: 155131 AIM number: 100289450 Census Bed Type: SNF/NF: 155 Total: 155 Census Payor Type: Medicare: 18 Medicaid: 114 Other: 23 Total: 155 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on 10/28/24.	F 0000	The facility respectfully requests paper compliance for this citation.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
shanika Willhite	Administrator	11/08/2024

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

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F 0550 SS=D Bldg. 00	483.10(a)(1)(2)(b)(1)(2) Resident Rights/Exercise of Rights Based on observation, record review, and interview, the facility failed to ensure each resident's dignity was maintained related to being exposed from the doorway and wearing a hospital gown while in bed during the day for 3 of 6 residents reviewed for dignity. (Residents 91, 120, and 92) Findings include: 1. On 10/15/24 at 10:36 a.m., 11:10 a.m. and 3:11 p.m., Resident 91 was observed in his room seated in his wheelchair. The resident was wearing a shirt and an incontinence brief. The resident's bed was located near the door and the door to the room was open. The resident was visible from the hallway. On 10/17/24 at 10:10 a.m., the resident was again seated in his wheelchair in his room wearing a shirt and his incontinence brief. The door to the resident's room was open and he was visible from the hallway. The record for Resident 91 was reviewed on 10/17/24 at 10:36 a.m. Diagnoses included, but were not limited to, Parkinson's disease, dementia with behavior disturbance, and major depressive disorder. The Annual Minimum Data Set (MDS) assessment, dated 9/5/24, indicated the resident was moderately impaired for daily decision making and required partial to moderate assistance for lower body dressing. The resident did not have a current care plan	F 0550	Munster Med INN Complaint Survey: 10/22/2024 Please accept the following as the facility's credible allegation of compliance. This plan of correction does not constitute an admission of guilt or liability by the facility and is submitted only in response to the regulatory requirement. F550 Resident Rights/Exercise of Rights What corrective action(s) will be accomplished for those residents found to have been affected by the 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 provide for privacy R92's plan of care was updated to reflect residents' preference to wear a facility gown while in bed. R91's Plan of care was updated to reflect the residents' preference to wear no pants while in room. How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken; All residents have the potential to be affected by the alleged deficient practice. What measures will be put into place or what systemic changes	11/08/2024

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	related to not wearing pants while in his room. During an interview on 10/18/24 at 11:14 a.m., the Assistant Director of Nursing indicated the resident should have had a care plan noting that he liked to wear a shirt and brief at times. 2. On 10/15/24 at 10:34 a.m., 11:10 a.m. and 3:11 p.m., Resident 120 was observed in his room in bed. The resident was wearing a t-shirt and an incontinence brief. His legs were not covered, the privacy curtain wasn't pulled, and he was visible from the hallway. On 10/16/24 at 11:18 a.m. and 3:59 p.m., the resident was observed in his room in bed. He was wearing a t-shirt and an incontinence brief. His legs were not covered, the privacy curtain wasn't pulled, and he was visible from the hallway. On 10/17/24 at 10:12 a.m., 11:35 a.m. and 2:14 p.m., the resident was observed in his room in bed. He was wearing a t-shirt and an incontinence brief. His legs were not covered, the privacy curtain wasn't pulled, and he was visible from the hallway. On 10/18/24 at 9:25 a.m., the resident was observed in his room in bed. He was wearing a t-shirt and an incontinence brief. His legs were not covered, the privacy curtain wasn't pulled, and he was visible from the hallway. The record for Resident 120 was reviewed on 10/18/24 at 9:30 a.m. Diagnoses included, but were not limited to, dementia with behavior disturbance, psychotic disorder with delusions, chronic obstructive pulmonary disease (COPD), and oxygen dependent.		will be made to ensure that the deficient practice does not recur; Staff were re-educated on: · Providing for resident privacy · Updating the residents' preferences to their plan of care How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance programs will be put into place. Facility Angel's will audit 10 residents 3 times per week to ensure privacy is maintained and residents who prefer to always wear gowns while in bed, preferences are updated in their plan of care. Director of Nursing/designee will present a summary of the audits to the Quality Assurance committee monthly for 6 months. Thereafter, if determined by the Quality Assurance committee, auditing and monitoring will be done quarterly and present quarterly at the QA meeting. Monitoring will be on going. Date by which systemic corrections will be completed: 11/8/2024	

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	The Quarterly Minimum Data Set (MDS) assessment, dated 7/11/24, indicated the resident was moderately impaired for daily decision making. A Care Plan, dated 5/24/24, indicated the resident preferred to wear only a brief, no other clothing or a gown, while in his room. Interventions included, but were not limited to, resident to be provided with dignity. During an interview on 10/18/24 at 11:14 a.m., the Assistant Director of Nursing indicated he would see if the resident would want the privacy curtain pulled and if not, the care plan would be updated to reflect that. 3. During random observations on 10/16/24 at 10:12 a.m. and 3:41 p.m., on 10/17/24 at 9:35 a.m., 11:25 a.m., and 2:10 p.m., and on 10/18/24 at 9:10 a.m. and 11:40 a.m., Resident 92 was observed lying in bed wearing a hospital gown. The record for Resident 92 was reviewed on 10/17/24 at 9:58 a.m. Diagnoses included, but were not limited to, protein calorie malnutrition, intermittent explosive disorder, high blood pressure, post traumatic stress disorder (PTSD), osteoarthritis, bipolar disorder, and intellectual disabilities. 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			

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	clothes to wear. During an interview on 10/18/24 at 10:35 a.m., the Second Floor Unit Manager indicated Social Service was responsible for updating all of the care plans regarding residents wearing hospital gowns. During an interview on 10/18/24 at 10:37 a.m., the Social Service Director indicated there was no care plan for the resident to be dressed in a hospital gown during the day. 3.1-3(t)			
F 0623 SS=A Bldg. 00	483.15(c)(3)-(6)(8) Notice Requirements Before Transfer/Discharge Based on record review and interview, the facility failed to ensure the resident's Responsible Party was notified in writing related to a transfer to the hospital for 2 of 3 residents reviewed for hospitalization. (Residents 7 and 16) Findings include: 1. The record for Resident 7 was reviewed on 10/18/24 at 2:10 p.m. Diagnoses included, but were not limited to, type 2 diabetes, left below the knee amputation, peripheral vascular disease (PVD), and dementia without behavior disturbance. The Significant Change Minimum Data Set (MDS) assessment, dated 9/2/24, indicated the resident was cognitively impaired for daily decision making. A Nurses' Note, dated 8/8/24 at 1:18 p.m., indicated the Wound Physician wrote an order for	F 0623	Munster Med INN Annual Survey: 10/22/2024 Please accept the following as the facility's credible allegation of compliance. This plan of correction does not constitute an admission of guilt or liability by the facility and is submitted only in response to the regulatory requirement. F623 Notice Requirements Before Transfer/Discharge What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; The responsible party of Resident 16 and 7 have been mailed copies of the facility transfer and bed hold policy. How the facility will identify other residents having the potential to	11/08/2024

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

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	with acute cholecystitis. The resident returned to the facility on 9/5/24. There was no indication the State transfer form was mailed to the resident's responsible party. During an interview on 10/22/24 at 3:00 p.m., the Director of Nursing indicated the State transfer form had not been mailed to the resident's responsible party. 3.1-12(a)(6)(ii) 3.1-12(a)(6)(iii)		Monitoring will be on going. Date by which systemic corrections will be completed: 11/8/2024	
F 0656 SS=D Bldg. 00	483.21(b)(1)(3) Develop/Implement Comprehensive Care Plan Based on record review and interview, the facility failed to ensure a comprehensive care plan was developed and in place for anti-anxiety medications for 1 of 33 resident care plans reviewed. (Resident 139) Finding includes: The record for Resident 139 was reviewed on 10/21/24 at 9:28 a.m. Diagnoses included, but were not limited to, type 2 diabetes mellitus, hypertension, and depression. The Quarterly Minimum Data Set (MDS) assessment, dated 8/23/24, indicated the resident was mildly cognitively impaired and received anti-anxiety and antipsychotic medications. A Physician's Order, dated 4/2/24, indicated the resident was to receive ABH (Ativan/Benadryl/Haldol) gel (a hospice medication for agitation) to the wrist topically two	F 0656	Munster Med-Inn Annual Survey: 10/22/2024 Please accept the following as the facility's credible allegation of compliance. This plan of correction does not constitute an admission of guilt or liability by the facility and is submitted only in response to the regulatory requirement. F656 Develop/Implement Comprehensive Care Plan What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; Resident 139's antianxiety medication care plan was initiated. How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action	11/08/2024

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	times a day for agitation and aggressive behavior. The Medication Administration Record (MAR), dated 10/2024, indicated the resident had received the ABH gel medication twice a day. There was a lack of any current care plan for the anti-anxiety medication, agitation, or aggressive behaviors. During an interview on 10/21/24 at 4:41 p.m., the Director of Nursing (DON) indicated there was an antipsychotic medication use care plan and there was an asthma care plan that mentioned use of anxiety medication as needed. There was no care plan in place related to the anti-anxiety medication's use for agitation or aggressive behaviors. 3.1-35(a)		will be taken; All residents have the potential to be affected by the same alleged deficient practice. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur; Clinical staff were re-educated on: · Developing care plans for residents related to medications such anxiolytics. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance programs will be put into place; MDS/designee will randomly audit 5 residents weekly to ensure care plans are in place. With a special focus on anxiolytic medications. MDS/designee will present a summary of the audits to the Quality Assurance committee monthly for 6 months. Thereafter, if determined by the Quality Assurance committee, auditing and monitoring will be done quarterly and present quarterly at the QA meeting. Monitoring will be on going. Date by which systemic corrections will be completed: 11/8/2024	
F 0657 SS=E Bldg. 00	483.21(b)(2)(i)-(iii) Care Plan Timing and Revision Based on observation, record review and interview, the facility failed to invite and hold care	F 0657	Munster Med INN Annual Survey: 10/22/2024	11/08/2024

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	planning conferences for residents and/or their family members. The facility also failed to update a care plan related to preferences of wearing a hospital gown for 6 of 33 residents whose care plans were reviewed. (Residents 1, 9, 129, 141, 72, and 31) Findings include: 1. During random observations on 10/15/24 at 2:32 p.m., on 10/16/24 at 3:57 p.m., and on 10/17/24 at 9:49 a.m., 11:36 a.m., and 2:08 p.m., Resident 1 was observed lying in bed wearing a hospital gown. The record for Resident 1 was reviewed on 10/17/24 at 1:35 p.m. Diagnoses included, but were not limited to, multiple sclerosis, neuromuscular bladder, vascular dementia, major depressive disorder, anemia, high blood pressure, anxiety, and pain. The 8/30/24 Quarterly Minimum Data Set (MDS) assessment indicated the resident was not cognitively intact and was severely impaired for daily decision making. The resident was dependent on staff for dressing. An outdated Care Plan, dated 4/27/21, indicated the resident's family preferred for the resident to wear a facility gown at all times when lying in bed. There was no current care plan indicating the resident wished to be dressed in a hospital gown during the day. During an interview on 10/18/24 at 10:25 a.m., CNA 2 indicated she had never dressed the resident in regular clothes.		Please accept the following as the facility's credible allegation of compliance. This plan of correction does not constitute an admission of guilt or liability by the facility and is submitted only in response to the regulatory requirement. F657 Care Plan Timing and Revision What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; A care conference was scheduled for resident 1, 72, 129, 31, 9, and 141. Care plans were updated for Resident's 1, 72, 129, 31, and 141 preferences to wear facility gowns while in bed. How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken; All residents have the potential to be affected by this alleged deficient practice. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur; Social Service was re-educated on: Scheduling Quarterly/Annual Care Conferences. Ensuring the resident/Responsible Party is invited to attend the conference.	

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	During an interview on 10/18/24 at 10:35 a.m., the Second Floor Unit Manager indicated Social Service was responsible for updating all of the transitional care plans regarding the residents wearing hospital gowns into the new point click care computer system. During an interview on 10/18/24 at 10:37 a.m., the Social Service Director indicated she had not had time to transfer the resident's care plan into point click care. 2. During a telephone interview on 10/16/24 at 2:28 p.m., Resident 9's son indicated he had received an invitation to maybe 1 or 2 care conferences, but he was working at the time the facility had them scheduled and no one from the facility had ever called him to see if it could be rescheduled. The record for Resident 9 was reviewed on 10/17/24 at 4:00 p.m. Diagnoses included but were not limited to, heart disease, dementia with behaviors, psychotic disorder with delusions, major depressive disorder, chronic pain, high blood pressure, and adult failure to thrive. The 8/29/24 Quarterly Minimum Data Set (MDS) assessment indicated the resident was severely impaired for decision making and was dependent on staff for activities of daily living. There was no documentation indicating the resident had a care planning conference in the last year. 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		Documenting Conference Date and Attendees in the resident's medical record. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance programs will be put into place; Administrator/Designee will audit care conferences scheduled for the week to ensure the resident/responsible party was invited to attend and the conference is documented in the resident's medical record. The Administrator/designee will present a summary of the audits to the Quality Assurance committee monthly for 6 months. Thereafter, if determined by the Quality Assurance committee, auditing and monitoring will be done quarterly and present quarterly at the QA meeting. Monitoring will be on going. Date by which systemic corrections will be completed: 11/8/2024	

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	plan meetings to the families. The unit manager would receive an email when the residents were scheduled. She indicated care plan meetings for the resident were not held when the family didn't show up. During an interview on 10/18/24 on 11:30 a.m., the Social Service Director indicated there had been no care plan meetings for the resident because the family doesn't show up. She was unaware a care plan meeting needed to be held even if the family did not attend and the resident was cognitively impaired. 3. During an interview on 10/15/24 at 11:26 a.m., Resident 129 indicated he had not had a care planning conference since he had been at the facility. The record for Resident 129 was reviewed on 10/17/24 at 2:15 p.m. The resident was admitted to the facility on 8/26/24. Diagnoses included, but were not limited to, COPD (chronic obstructive pulmonary disease), chronic respiratory failure, heart failure, heart disease, anxiety, palliative care, dependence on oxygen, and chronic pain. The 9/1/24 Admission Minimum Data Set (MDS) assessment indicated the resident was cognitively intact for daily decision making. There was no documentation the resident had a care conference within the first 30 days of admission. During an interview on 10/18/24 at 11:30 a.m., the Second Floor Social Service Director indicated the resident had not had a care plan meeting since admission.			

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	4. During an interview on 10/15/24 at 2:51 p.m., Resident 141 indicated she had not had a care planning conference since she had been at the facility. The record for Resident 141 was reviewed on 10/18/24 at 3:10 p.m. The resident was admitted on 5/13/24 and had the diagnoses of peripheral venous insufficiency, type 2 diabetes, morbid obesity, high blood pressure, osteoarthritis, and major depressive disorder. The 9/25/24 Quarterly Minimum Data Set (MDS) assessment indicated the resident was cognitively intact for daily decision making. There was no documentation the resident had a care planning conference within the first 30 days of admission and after the first Quarterly MDS assessment. During an interview on 10/21/24 on 12:15 p.m., the Social Service Director indicated there had been no care plan meetings for the resident. During an interview on 10/22/24 at 8:30 a.m., Administrative Assistant 1 indicated she received a list of residents who needed care plan meetings set up from the MDS office around the third week of the month. She then prepared the letters for when their meetings were scheduled and sent them out to the families or gave them to the resident if they were their own responsible party . Social Services was responsible for inviting the residents to the meetings. 5. The record for Resident 72 was reviewed on 10/18/24 at 9:59 a.m. Diagnoses included, but were not limited to, heart failure, dementia, diabetes, anemia, and high blood			

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	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 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 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 Director of Nursing (DON) indicated the care plan meetings should have been documented once they were completed, and any invites should have been followed up on. During an interview on 10/21/24 at 11:47 a.m., the SSD indicated the resident did not have a care plan meeting this year because he just received a			

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	guardian. 6. The record for Resident 31 was reviewed on 10/18/24 at 1:26 p.m. Diagnoses included, but were not limited to, kidney disease, paraplegia, heart failure, dysphagia (difficulty swallowing), hypertension (high blood pressure), anemia (low iron), and diabetes. The Quarterly Minimum Data Set (MDS) assessment, dated 8/16/24, indicated the resident was cognitively intact for daily decision making. A Social Service Progress Note, dated 1/9/24 at 1:17 p.m., indicated the staff member met with the resident to discuss his quarterly assessment. There was no documentation about inviting the resident to her care conference. There was no documentation of the resident being invited to attend her 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 then she got an email on when they were scheduled. During an interview on 10/18/24 at 2:33 p.m., the Director of Nursing (DON) indicated the care plan meetings should have been documented once they were completed, and invites should have been followed up on. During an interview on 10/21/24 at 11:47 a.m., the Social Service Director indicated Resident 31 had not had a care plan meeting this year. 3.1-35(d)(2)(B)			

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F 0677 SS=E Bldg. 00	483.24(a)(2) ADL Care Provided for Dependent Residents Based on observation, record review, and interview, the facility failed to ensure dependent residents received ADL (Activities of Daily Living) care related to long and dirty fingernails and facial hair for 4 of 11 residents reviewed for ADL's. (Residents 1, 6, 129, and 116) Findings include: 1. During random observations on 10/15/24 at 2:32 p.m., on 10/16/24 at 3:57 p.m., on 10/17/24 at 9:49 a.m., 11:36 a.m. and 2:08 p.m., and on 10/18/24 at 9:10 a.m., Resident 1 was observed with long fingernails on both hands. The record for Resident 1 was reviewed on 10/17/24 at 1:35 p.m. Diagnoses included, but were not limited to, multiple sclerosis, neuromuscular bladder, vascular dementia, major depressive disorder, anemia, high blood pressure, anxiety, and pain. The 8/30/24 Quarterly Minimum Data Set (MDS) assessment indicated the resident was not cognitively intact and was severely impaired for daily decision making. The resident was dependent on staff for dressing, toileting, eating, personal and oral hygiene. The Care Plan, dated 3/12/24, indicated the resident had an ADL self care deficit. The CNA task section under bathing, indicated nail care was provided to the resident on 10/13-10/17/24. During an interview on 10/18/24 at 10:25 a.m.,	F 0677	Munster Med INN Annual Survey: 10/22/2024 Please accept the following as the facility's credible allegation of compliance. This plan of correction does not constitute an admission of guilt or liability by the facility and is submitted only in response to the regulatory requirement. F677 ADL Care Provided for Dependent Residents What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; R116, R1, R6, and R129 Nails were cleaned and trimmed immediately R6 and R129 were immediately assisted with trimming facial hair. How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken; All residents requiring assistance with ADL Care have the potential to be affected by the same alleged deficient practice. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur; Nursing Staff will be educated on: · Grooming residents' facial hair, cleaning/trimming nails, and	11/08/2024

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	CNA 2 indicated she had not cut the resident's fingernails. During an interview on 10/18/24 at 10:35 a.m., the Second Floor Unit Manager was not aware the resident's fingernails were that long. 2. During an interview on 10/16/24 at 11:30 a.m., Resident 6 indicated her fingernails were very long and in need of trimming. The nails on both hands were also dirty. The resident had a moderate amount of facial hair on her chin, and wanted that cut as well. During random observations on 10/17/24 at 9:50 a.m., 11:36 a.m., and 2:30 p.m., the resident's fingernails were still long and dirty and her facial hair remained to her chin and neck areas. The record for Resident 6 was reviewed on 10/17/24 at 10:39 a.m. Diagnoses included, but were not limited to, atrial fibrillation, heart failure, major depressive disorder, reduced mobility, Alzheimer's disease late onset, dementia with behaviors, high blood pressure, and adult failure to thrive. The Quarterly Minimum Data Set (MDS) assessment, dated 10/2/24, indicated the resident was cognitively intact for daily decision making. The resident needed substantial to maximal assistance with personal hygiene. A Care Plan, revised on 8/20/24, indicated the resident had an ADL self care deficit. The CNA task section under bathing, indicated nail care had been completed on 9/18, 9/19, 9/24, 9/25, 9/27-9/29, 10/1-10/9, 10/14 and 10/16/24.		assistance with ADL care per plan of care. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance programs will be put into place; Facility Angels will Aduit 10 residents 2 times weekly to ensure that grooming is completed with ADL care with a special focus on nailcare and facial hair. Director of Nursing/designee will present a summary of the audits to the Quality Assurance committee monthly for 6 months. Thereafter, if determined by the Quality Assurance committee, auditing and monitoring will be done quarterly and present quarterly at the QA meeting. Monitoring will be on going. Date by which systemic corrections will be completed: 11/8/2024	

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	There was no documentation indicating the resident had been shaved. During an interview on 10/18/24 at 10:20 a.m. CNA 2 indicated the resident did not refuse care and the activity department provided nail care for her once a week. She was unaware the resident's nails were long and dirty and that she had facial hair on her chin. During an interview on 10/18/24 at 11:00 a.m., the Second Floor Unit Manager indicated the activity department was not responsible for cutting and cleaning the resident's nails. 3. During an interview on 10/15/24 at 11:29 a.m., Resident 129 indicated he had long and dirty fingernails that needed to be cut. He also indicated he wanted a shave and liked to be clean shaven. During random observations on 10/16/24 at 3:46 p.m., on 10/17/24 at 11:37 a.m., 2:25 p.m. and 3:00 p.m., and on 10/18/24 at 9:19 a.m., the resident was observed with long and dirty fingernails as well as a large amount of facial hair on his cheeks and neck area. The record for Resident 129 was reviewed on 10/17/24 at 2:15 p.m. The resident was admitted to the facility on 8/26/24. Diagnoses included, but were not limited to, COPD (chronic obstructive pulmonary disease), chronic respiratory failure, heart failure, heart disease, anxiety, palliative care, dependence on oxygen, and chronic pain. The 9/1/24 Admission Minimum Data Set (MDS) assessment indicated the resident was cognitively			

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	intact for daily decision making. The resident needed substantial/maximal assist for bathing and personal hygiene. A Care Plan, dated 8/27/24, indicated the resident had an ADL self care deficit. The CNA task section under bathing, indicated nail care was provided on 9/19, 9/23, 9/25, 9/26, 9/27, 9/28, 9/30-10/4, and 10/16/24. The resident received a complete bed bath on 9/19, 9/23-9/29, 10/1-10/4, 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. During an interview on 10/21/24 at 11:55 p.m., the Second Floor Unit Manager indicated nails were to be trimmed and facial hair was to be removed as needed. 4. On 10/15/24 at 2:39 p.m., Resident 116 was observed with whiskers on her chin and long fingernails with dark dirty debris underneath the nails. On 10/17/24 at 10:03 a.m., the resident had whiskers on her chin and her nails were long and dirty. On 10/18/24 at 9:24 a.m. and 11:33 a.m., the resident was observed in bed and her fingernails were still long and dirty with dark debris beneath the nails. On 10/21/24 at 11:53 a.m., the resident was observed in bed and her fingernails were still long and dirty with dark debris under her nails. The record for Resident 116 was reviewed on 10/18/24 at 9:24 a.m. Diagnoses included, but			

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	were not limited to, hyperlipidemia (high cholesterol), hypertension (high blood pressure), dysphagia (difficulty swallowing), and hearing loss in both ears. The Quarterly Minimum Data Set (MDS) assessment, dated 8/26/24, indicated the resident was severely impaired for daily decision making. The resident had range of motion impairment on both sides of her lower extremities and was dependent on staff with all activities of daily living (ADL's). A Care Plan, dated 6/19/24, indicated the resident had a communication problem related to deafness. A Care Plan, dated 6/19/24, indicated the resident had severe cognitive impairment. Interventions were to explain and anticipate care with all ADL's. Nail care was documented as completed on 10/14, 10/16, 10/19, and 10/20/2024. During an interview on 10/18/24 at 4:34 p.m., the Director of Nursing (DON) indicated the resident's nails and beard should have been groomed. During an interview on 10/21/24 at 11:56 a.m., LPN 2 indicated she thought they cut and cleaned the resident's nails on 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 Based on observation, record review, and interview, the facility failed to ensure areas of bruising and scabbing were assessed and	F 0684	Munster Med-Inn Annual Survey: 10/22/2024 Please accept the following as the	11/08/2024

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	monitored, and treatments were in place for non-pressure skin injuries for 3 of 3 residents reviewed for skin conditions non-pressure related. (Residents 56, 79, and 6) Findings include: 1. On 10/15/24 at 11:07 a.m., Resident 56 was observed in his room in bed. He had an area of reddish/purple discoloration to the top of his left hand. The record for Resident 56 was reviewed on 10/18/24 at 10:30 a.m. Diagnoses included, but were not limited to, Alzheimer's disease, anemia, and type 2 diabetes. The Quarterly Minimum Data Set (MDS) assessment, dated 9/20/24, indicated the resident was cognitively impaired for daily decision making and required substantial to maximum assistance with rolling left and right and for chair to bed transfers. The resident did not have a current care plan related to the bruising to his left hand. A Weekly Skin Observation form, dated 10/17/24, indicated the resident's skin was intact and there was no documentation related to bruising. During an observation on 10/18/24 at 11:17 a.m., the Assistant Director of Nursing confirmed the discoloration to the top of the resident's left hand. He indicated he would get an order to monitor the bruising. A Physician's Order, dated 10/18/24, indicated the bruise to the resident's left hand was to be monitored every shift until resolved.		facility's credible allegation of compliance. This plan of correction does not constitute an admission of guilt or liability by the facility and is submitted only in response to the regulatory requirement. F684 Quality of Care What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; Resident's 79 treatment was re-applied and care plan for resident removing treatment in place. R56, and 6's bruises were assessed. MD was notified. New orders were obtained to monitor bruising. How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken; All residents have the potential to be affected by the same alleged deficient practice. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur; Nurses were re-educated on: · Addressing and assessing changes in skin condition such as bruises, obtaining orders for treatment, and implementation of treatment. Assistive clinical staff were educated on: · Notifying the nurse of any	

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	2. On 10/15/24 at 10:40 a.m., 11:07 a.m. and 3:14 p.m., Resident 79 was observed in his room in bed. The resident had a large open area to his left upper jaw that was not covered. On 10/16/24 at 11:34 a.m., 12:12 p.m., and 3:55 p.m., the resident was seated in his wheelchair propelling himself around the unit. The open area to his left upper jaw was not covered. The record for Resident 79 was reviewed on 10/17/24 at 10:55 a.m. Diagnoses included, but were not limited to, dementia with behavior disturbance, Alzheimer's disease with late onset, anxiety, and major depressive disorder. The 8/17/24 Quarterly Minimum Data Set (MDS) assessment indicated the resident was cognitively impaired for daily decision making. The resident was coded as having an open lesion other than ulcers, rashes, or cuts. A Care Plan, dated 4/26/24, indicated the resident had a scabbed area (history of cancer) to the left jaw. Interventions included, but were not limited to, follow facility protocols for treatment of injury. A Physician's Order, dated 9/12/24, indicated the resident's left face wound was to be cleansed with normal saline and/or wound cleanser and apply Aldara 5% cream (a medication to treat skin cancer) to the wound and cover with a dry dressing every day shift on Monday, Tuesday, Wednesday, Thursday, and Friday for 6 Weeks and as needed (PRN). The October 2024 Treatment Administration Record (TAR), indicated the treatment to the left		change in residents' skin conditions. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance programs will be put into place; Facility Angels/designee will complete observation rounds on 10 residents 3 times per week to ensure areas of bruising are reported to the nurse. Director of Nursing/designee will present a summary of the audits to the Quality Assurance committee monthly for 6 months. Thereafter, if determined by the Quality Assurance committee, auditing and monitoring will be done quarterly and present quarterly at the QA meeting. Monitoring will be on going. Date by which systemic corrections will be completed: 11/8/2024	

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	side of the resident's face was signed out as being completed as ordered. The Wound Physician Progress Note, dated 10/10/24, indicated the resident had a basal cell skin cancer to the left side of his face that measured 3.5 centimeters (cm) by 3.5 cm x 1.0 cm. Nurses' Notes, dated 8/20/24 at 1:10 p.m., indicated the resident continued to pick at the area to the lower jaw after he was reminded not to touch it because of the spread of infection. Nurses' Notes, dated 9/2/24 at 3:52 p.m., indicated the resident was picking at the area to the lower jaw. Nurses' Notes, dated 10/16/24 at 9:15 a.m., indicated the treatment to the side of the resident's face was completed but he refused to keep the dressing on. The resident had been reminded of the importance of keeping the dressing on to help aide with infection but the resident refused to keep it on. During an interview on 10/18/24 at 11:14 a.m., the Assistant Director of Nursing (ADON) indicated the resident did have a history of removing the dressing to his left jaw and he thought a care plan was in place. On 10/18/24 at 11:56 a.m., the ADON presented a care plan that was dated 10/16/24, which indicated the resident displayed anxious behaviors by repetitively scratching at his wound and he was resistant to treatment orders by removing his bandage on a regular basis. There was no care plan prior to 10/16/24 addressing the behavior of the resident removing			

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	his dressing on a regular basis. 3. During random observations on 10/16/24 at 11:32 a.m. and on 10/17/24 at 9:50 a.m., 11:36 a.m., and 2:30 p.m., Resident 6 was observed wearing short sleeves and geri sleeves (protective skin coverings) to both arms. At those times, the resident was observed with a red and purple bruised area to the left upper arm above her elbow. The record for Resident 6 was reviewed on 10/17/24 at 10:39 a.m. Diagnoses included, but were not limited to, atrial fibrillation, heart failure, major depressive disorder, reduced mobility, Alzheimer's disease late onset, dementia with behaviors, high blood pressure, and adult failure to thrive. The Quarterly Minimum Data Set (MDS) assessment, dated 10/2/24, indicated the resident was cognitively intact for daily decision making. The resident needed substantial to maximal assistance with personal hygiene and received an anticoagulant (blood thinner) medication. The Care Plan, revised on 6/21/23, indicated the resident had the potential for complications related to anticoagulant therapy use. The approaches were to observe and report adverse reactions such as bruising and do a skin inspection per facility protocol. Physician's Orders, dated 7/3/24, indicated skin assessments were to be completed weekly and new skin issues were to be documented per protocol. Physician's Orders, dated 7/29/24, indicated Xarelto (an anticoagulant medication) 15 milligrams (mg), give 1 tablet by mouth one time a day.			

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	The CNA task section under skin observations, indicated there were no areas checked for 10/1 through 10/17/24. A Skin/Wound Note, dated 10/15/24 at 8:31 a.m., indicated the resident was seen by wound care today and bruising to the right arm/hand had resolved. No further recommended monitoring at the time. A Weekly Skin Observation, dated 10/12/24, indicated no new skin issues. There was no documentation of the bruised area to the upper left arm in nursing progress notes. The resident had a shower on 10/15/24 and a complete bed bath on 10/16-10/18/24. During an interview on 10/18/24 at 11:15 a.m., RN 1 indicated she was not made aware the resident had a bruised area to her upper left arm and she would go and assess the area now. During an interview on 10/18/24 at 11:30 a.m., the Second Floor Unit Manager indicated the resident bruised very easily and had the diagnoses of purpura (a condition that causes red or purple spots or patches to appear on the skin or in mucus membranes.), but she would assess the area as well. Nurses' Notes, dated 10/18/24 at 12:01 p.m., indicated the resident had a reddened area to the left arm right above the elbow that measured 2.5 centimeters (cm) by 2.3 cm. The resident was unsure of how she got it and upon assessment the resident was noted to be leaning to one side in the wheelchair. The placement of the bruise			

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	matched directly to where the arm rest was on the wheelchair. Physical Therapy was asked to assess the resident's sitting position and wheelchair. Therapy was in agreement that the bruise met the height of the arm rest and padded the arm rests. During an interview on 10/18/24 at 2:45 p.m., the Director of Nursing was informed of the bruise and had no additional information to provide. The current 9/1/20 "Skin Condition Assessment and Monitoring" policy, 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 the charge nurse who would perform the detailed assessment. 3.1-37(a)			
F 0686 SS=D Bldg. 00	483.25(b)(1)(i)(ii) Treatment/Svcs to Prevent/Heal Pressure Ulcer Based on observation, record review, and interview, the facility failed to ensure preventative measures were in place to prevent pressure ulcers related to the development of a new pressure area behind a resident's ear for 1 of 2 residents reviewed for pressure ulcers. (Resident 129) Finding includes: During a random observation on 10/17/24 at 2:25 p.m., Resident 129 was observed up and dressed wheeling himself down the hallway. The resident was not wearing any shoes and did not have his oxygen on. CNA 1 told the resident she would help him get something on his feet and instructed him to go back to his room. As the resident turned his wheelchair around, his left ear was observed	F 0686	Annual Survey: 10/22/2024 Munster Med-Inn Please accept the following as the facility's credible allegation of compliance. This plan of correction does not constitute an admission of guilt or liability by the facility and is submitted only in response to the regulatory requirement. F686 Treatment/Svcs to Prevent/Heal Pressure Ulcers What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; Resident 129's skin was	11/08/2024

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	with dried blood behind it. On 10/17/24 at 3:00 p.m., the resident was observed in his room wearing oxygen via a nasal cannula. At that time, he was asked to pull back his right ear lobe so the area behind the ear could be viewed. The area behind the ear was open with both fresh and dried blood. The resident was asked to pull back his left ear lobe and there was dried blood behind that ear as well. The resident indicated both areas were painful and had been there "for a while." There were no padded protectors observed over the oxygen tubing to protect his ears. On 10/17/24 at 3:04 p.m., LPN 1 was asked to asses the resident's ears. At that time, she removed the oxygen tubing from behind his ears and both pressure ulcers were observed. The oxygen tubing was so tight around the resident's ears, there were indentations on his face. During an interview at that time, LPN 1 indicated she was unaware the resident had any pressure ulcers behind his ears and she would contact the wound nurse to assess and treat the wounds. The record for Resident 129 was reviewed on 10/17/24 at 2:15 p.m. The resident was admitted to the facility on 8/26/24 and his diagnoses included, but were not limited to, COPD (chronic obstructive pulmonary disease), chronic respiratory failure, heart failure, heart disease, anxiety, palliative care, dependence on oxygen, and chronic pain. The 9/1/24 Admission Minimum Data Set (MDS) assessment indicated the resident was cognitively intact for daily decision making. The resident needed substantial/maximal assist for bathing and		immediately assessed. Resident 129's MD was notified, and orders were obtained and implemented for newly identified pressure ulcer. How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken; All residents with pressure ulcers have the potential to be affected by the same alleged deficient practice. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur; Nurses were re-educated on the following: · Obtaining orders and implementing treatment for pressure/new skin conditions. · Notifying MD and resident responsible party of new pressure/skin conditions. Assistive staff were re-educated on: · Notifying the nurse immediately when a treatment has become soiled or detached from wound. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance programs will be put into place; Wound nurse/designee will randomly audit 5 residents identified at risk for skin breakdown and residents with existing skin breakdown to ensure	

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	personal hygiene. The resident had no pressure ulcers. A Care Plan, dated 8/27/24, indicated the resident had the potential for pressure ulcers. The approaches were to monitor for signs and symptoms of skin breakdown and notify the physician of changes. The last Weekly Skin Review Assessment was dated 10/14/24, and only mentioned the resident had shingles. The resident received a complete bed bath on 9/19, 9/23-9/29, 10/1-10/4, 10/6-10/9, 10/12-10/14, and 10/16-10/17/24. Physician's Orders, dated 8/26/24, indicated the resident was to have weekly skin assessments and new skin issues were to be documented per protocol. There was no order for protective padding for the oxygen tubing. A Wound Assessment by the wound nurse, dated 10/17/24, indicated the following: - Left ear: Stage 3, with 65% of Epithelial (pale pink or red) tissue, serous drainage, and measured 0.3 centimeters (cm) by 1.50 cm by 0.1 cm. - Right ear: Stage 3, with 65% of Epithelial (pale pink or red) tissue, serous drainage, and measured 1.5 cm by 0.3 cm by 0.1 cm. - Left side of nose: Stage 3, with 20% Epithelial (pale pink or red)-20%, 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., indicated the resident was seen by wound care today to follow up on new open areas to his		skin conditions are documented and orders are obtained, and treatments are in place per orders. Director of Nursing/designee will present a summary of the audits to the Quality Assurance committee monthly for 6 months. Thereafter, if determined by the Quality Assurance committee, auditing and monitoring will be done quarterly and present quarterly at the QA meeting. Monitoring will be on going. Date by which systemic corrections will be completed: 11/8/2024	

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	bilateral ears as reported by staff. On visualization, wounds were noted to his bilateral ears and left side of the nose from the oxygen tubing. The resident was noted in some minor discomfort from these areas. New treatments were rendered and foam 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. During an interview on 10/17/24 at 3:30 p.m., the Second Floor Unit Manager indicated the resident had a skin assessment on 10/14/24 and the pressure ulcers were not there. She had no additional information to provide. The current 9/1/20 "Skin Condition Assessment and Monitoring" policy, 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 the charge nurse who would perform the detailed assessment. 3.1-40(a)(1)			
F 0689 SS=G Bldg. 00	483.25(d)(1)(2) Free of Accident Hazards/Supervision/Devices A. Based on observation, record review, and interview, the facility failed to ensure mechanical lift straps were safe for use prior to a transfer of a dependent resident for 1 of 1 resident reviewed for falls. (Resident B) This deficient practice resulted in a strap breaking during a transfer, the resident	F 0689	Munster Med INN Annual Survey: 10/22/2024 Please accept the following as the facility's credible allegation of compliance. This plan of correction does not constitute an	11/08/2024

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	falling from the lift, and the resident sustaining a left femur fracture. B. Based on observation, record review, and interview, the facility failed to ensure hot water temperatures were below 120 degrees Fahrenheit on 2 of 4 floors throughout the facility. (The 5th and 2nd floors) Findings include: A. A confidential interview indicated Resident B fell from a mechanical lift when the sling straps broke, and the resident sustained a leg fracture. On 10/15/24 at 2:54 p.m., Resident B was observed in bed. A blue leg immobilizer was observed on the resident's left leg. The record for Resident B was reviewed on 10/17/24 at 1:26 p.m. Diagnoses included, but were not limited to, displaced oblique fracture of the shaft of the left femur, vascular dementia with behavior disturbance, type 2 diabetes, protein-calorie malnutrition, and orthopedic aftercare. The Quarterly MDS assessment, dated 8/25/24, indicated the resident was cognitively impaired for daily decision making and used a mechanical lift for transfers. The resident was dependent on staff for bed mobility and transfers. There had been no falls since the last assessment. A Care Plan, dated 9/3/24, indicated the resident was at risk for falls and injury from falls. Nurse's Notes, dated 10/5/24 at 9:00 a.m., indicated the nurse was summoned to the resident's room. The two CNA's who were in the resident's room at		admission of guilt or liability by the facility and is submitted only in response to the regulatory requirement. F689 Free of Accident Hazards/Supervision/Devices What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; · On 10/5/2024 a full house audit of all hoyer lift pads was completed to ensure no pads have any tears, rips, or worn areas. · Hoyer/mechanical lift education including return demonstration was competed with clinical staff. · The facility hot water tank temperature was immediately decreased, and the water temperature was checked on all floors every hour x 4 hours to ensure levels were maintained within the appropriate range. · A service call was placed to Precision Service to check the water heater and related components · The facility Medical Director was updated, and a recommendation was given to supply each unit with a thermometer to test water temperature if they suspect temperatures are too warm. Thermometers were placed on all units. How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action	

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	that time indicated the resident fell. The CNA's indicated the resident fell during a transfer from the bed to the wheelchair while using the mechanical lift. The mechanical sling strap broke and the resident's left leg fell from the sling. The resident was complaining of pain to the left leg. The Physician was notified, orders were obtained to send the resident to the emergency room for evaluation, and 911 was contacted for transport. Hospital x-ray results of the left knee, dated 10/5/24, indicated the resident had a new left femur fracture. The resident was identified as having severely demineralized bones. The investigation completed by the facility was dated 10/5/24. The investigation documentation indicated two staff members were transferring the resident via the mechanical lift. There were no tears or rips to the mechanical sling prior to starting the transfer. As staff started to lift the resident and move them, the blue strap on the left side broke and the resident's leg hit the floor. The resident was then lowered to the floor. As the resident was being unhooked from the mechanical sling pad, two more blue straps tore. Both employees assisting with the transfer indicated they did not observe any fraying or tears to the mechanical lift sling pad prior to starting the transfer. There was no documentation which indicated the mechanical lift sling straps were checked prior to the transfer. A facility post-incident audit, dated 10/5/24, identified one additional mechanical lift sling was identified to have damage, was taken out of service, and replaced. Starting on 10/5/24, staff were re-educated on the use of the mechanical lift and maintaining slings,		will be taken; All residents have the potential to be affected by the same alleged deficient practice. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur; Staff were in-serviced on the following related to mechanical lifts: · Hoyer education with return demonstration · Checking hoyer pads for rips, tears, and worn areas · Laundry staff to inspect hoyer pads with each wash and document each inspection Staff were in-serviced on the following related to water temperatures: · Acceptable water temperatures range · Notifying maintenance and the administrator if the water temperature is below or above the acceptable range. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance programs will be put into place; Administrator/designee will audit/inspect 5 hoyer lift pads weekly to ensure they are in good condition. The maintenance director/designee will check water temperature 5 times per week on alternating floors to ensure water	

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	such as checking for damage before use. Ongoing audits of the mechanical lift sling pads were initiated. Laundry staff were responsible for inspecting the slings when they would need to be laundered. If the sling was torn or frayed, the sling would be taken out of service. Staff were also to inspect the mechanical lift slings prior to use. A Fall Interdisciplinary Team (IDT) Note, dated 10/8/24 at 10:18 a.m., indicated the resident was transferred by two CNA's via the mechanical lift from the bed to the wheelchair. The resident had a witnessed fall to the floor. Upon assessment, the resident complained of pain to the left hip. The resident was not moved and their position was maintained until EMS arrived. The root cause of the fall was a fall during a transfer from the bed to the wheelchair. The IDT note did not indicate the fall was due to a broken mechanical sling strap. Physician's Orders, dated 10/11/24, indicated the resident was non-weight bearing to the left femur and the left leg immobilizer was to stay in place, but could be removed for hygiene and skin checks. A Care Plan, dated 10/14/24, indicated the resident was at risk for complications, including changes in mobility, secondary to oblique fracture of the left femur status post-roding and surgical aftercare. Interventions included, but were not limited to, anticipate and meet needs, be sure call light was within reach, and respond promptly to all requests for assistance. During an interview on 10/18/24 at 2:55 p.m., CNA 2 indicated the resident was transferred with two staff assistance. The CNA also indicated that the mechanical lift sling was checked prior to transferring the resident and no frays were noted.		temperatures are maintained within the appropriate range. The Administrator/designee will present a summary of the audits to the Quality Assurance committee monthly for 6 months. Thereafter, if determined by the Quality Assurance committee, auditing and monitoring will be done quarterly and present quarterly at the QA meeting. Monitoring will be on going. Date by which systemic corrections will be completed: 11/8/2024	

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	During an interview, on 10/21/24 at 4:20 p.m., Housekeeper 1 indicated mechanical lift slings were not inspected by laundry staff for damage prior to 10/5/24. Housekeeper 1 indicated, after 10/5/2024, the slings were labeled with a number, and after the slings were washed the laundry staff should inspect the slings for damage then hang them to dry. During the interview, a sheet of paper, dated 10/2024, was observed taped to a dryer. The paper indicated the mechanical lift slings were observed to have no damage on 10/2/24, 10/6/24, 10/13/24, 10/15/24 through 10/17/24, and 10/20/24 through 10/21/24. The paper indicated the slings were not inspected for damage between 10/3/24 and 10/5/24. During an interview, on 10/22/24 at 8:35 a.m., the Laundry Supervisor indicated the laundry staff was responsible for monitoring the mechanical lift sling straps prior to and after 10/5/24. The Laundry Supervisor indicated he was not sure documentation could be provided to show the mechanical lift slings were inspected between January 2024 and 10/5/2024. During an interview, on 10/22/24 at approximately 9:35 a.m., the Laundry Supervisor provided mechanical lift audit sheets, dated January 2024 through April 2024, and May 2025 through October 2025. The October 2024 mechanical lift audit sheets were not provided by the Laundry Supervisor to determine if the lift slings were effectively inspected for damage prior to 10/5/24. During an interview, on 10/22/24 at 3:04 p.m., the Administrator indicated the mechanical lift slings were inspected by laundry staff prior to the incident with the resident on 10/5/24. She indicated when the mechanical lift slings were			

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	sent to laundry, the slings were to be inspected after washing. If any fraying or tears were noted, the sling was to be taken out of service and replaced. The Administrator indicated the Laundry Supervisor stated the audits were being completed prior to the incident and she took his word for it, he did not provide her with any audit sheets. During a phone interview on 10/22/24 at 3:20 p.m., the Laundry Supervisor indicated he may have been in a hurry, and he didn't know why the May through October audit sheets were dated 2025. He also indicated he may not have been wearing his glasses and that was why the wrong lines were checked for the month of October, he did not state that he or staff had checked them on those dates. The current facility policy related to the mechanical lift did not specify how often the Hoyer slings were to be inspected. A professional reference, titled "Patient Lifts Safety Guide," found at https://www.fda.gov/files/medical%20devices/published/Patient-Lifts-Safety-Guide.pdf, indicated, " ...Examine sling and attachment areas for tears, holes and frayed seams. 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 bathroom of room 517 was hot to touch. At 11:34 a.m., the Maintenance Supervisor arrived on the fifth floor, which was the secured memory care unit, and checked the water temperature. The bathroom water temperature in room 517 registered 134.5 degrees Fahrenheit. At 11:35 a.m., the Maintenance			

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	Supervisor measured the bathroom hot water temperature in room 502. The temperature was 137 degrees Fahrenheit. During an interview, on 10/16/24 at 11:40 a.m., the Maintenance Supervisor indicated the water was usually hotter on the fifth floor and it cooled down on the lower floors due to the boiler being located above the fifth floor. He also indicated he checked the water temperatures daily. Observation of the holding tanks on 10/16/24 at 11:40 a.m., indicated one water tank was holding at 120 degrees Fahrenheit, and the second holding tank was registering 134 degrees Fahrenheit. The electronic temperature gauge was set at 134 degrees Fahrenheit. The temperature was turned down at that time to register between 105- and 110-degrees Fahrenheit. The Maintenance Supervisor indicated it would take some time for the water to cool down and he did not know who set the thermostat to 134 degrees Fahrenheit. The Maintenance Supervisor indicated the thermostats should have been set between 110-115 degrees Fahrenheit to ensure the temperature was maintained between 100-120 degrees Fahrenheit. During an interview on 10/16/24 at 1:30 p.m., the Administrator indicated the water temperatures were being checked hourly on all units and staff had already been inserviced related to checking the water temperatures. The Administrator indicated the Maintenance Supervisor was responsible for checking the water temperature weekly. A Water Temperature Audit Sheet, provided by the Administrator, indicated on 10/16/24 at 1:02 p.m., the bathroom water temperature in room 502			

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	registered 120.8 degrees Fahrenheit. B2. On 10/16/24 at 11:36 a.m., the hot water temperature in the bathroom of room 216 was hot to touch. At 11:40 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. During an observation, on 10/16/24 between 11:45 a.m. and 11:55 a.m., the Maintenance Director was observed to measure the hot water temperature on the second floor with the following results: - Room 209: 136 degrees Fahrenheit. - Room 212: 137 degrees Fahrenheit. - Room 215: 136 degrees Fahrenheit. - Room 216: 137 degrees Fahrenheit. During the Environmental Tour, on 10/22/24 at 10:30 a.m., the Maintenance Supervisor was observed to measure hot water temperatures in random rooms on the second floor. The water temperatures measured 114 degrees Fahrenheit. Water temperatures in random rooms on the fifth floor measured 114.5 degrees Fahrenheit. During an interview, on 10/22/24 at 11:00 a.m., the Maintenance Supervisor indicated a water line was torn, was immediately repaired, the hot water tank temperature was turned down, and the water temperature of the holding tank was 115 degrees Fahrenheit. This citation relates to Complaints IN00444806, IN00444914, and IN00445179. 3.1-45(a)(1) 3.1-45(a)(2)			
F 0693 SS=D	483.25(g)(4)(5) Tube Feeding Mgmt/Restore Eating Skills			

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MUNSTER MED-INN	7935 CALUMET AVE MUNSTER, IN 46321

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
Bldg. 00	Based on observation, record review, and interview, the facility failed to ensure enteral tube feedings were infusing at the correct time through a peg tube (a tube inserted directly into the stomach for nutrition) for 1 of 1 resident reviewed for tube feeding. (Resident 113) Finding includes: On 10/18/24 at 9:37 a.m., Resident 113 was observed lying in bed with the head of the bed (HOB) elevated. The resident's tube feeding was running at 70 milliliter/hour (ml/hr). The tube feeding bottle was dated 10/17/24. Written on the front of the bottle with pen was a start time of 10:00 a.m., and an end time of 6:00 a.m. At 10:09 a.m., the tube feeding dated 10/17/24 was still running at 70 ml/hr. There was a new tube feeding bottle and tubing on the bedside table that was dated 10/18/24 and indicated a start time of 10:00 a.m. At 10:36 a.m., the tube feeding was shut off by QMA 1 for the resident's medication pass. At 10:47 a.m., the tube feeding bottle dated 10/18/24 was on and running at 70 ml/hr. During an interview at the time, QMA 1 indicated she had started the 10:00 a.m. tube feeding for the day and changed out the tubing. The record for Resident 113 was reviewed on 10/18/24 at 10:00 a.m. Diagnoses included, but were not limited to, hemiplegia (paralysis on one side of the body), stroke, depression, dementia, anxiety, dysphagia (difficulty swallowing), and diabetes. The Quarterly Minimum Data Set (MDS) assessment, dated 7/29/24, indicated the resident was severely impaired for daily decision making	F 0693	Munster Med-Inn Annual Survey: 10/22/2024 Please accept the following as the facility's credible allegation of compliance. This plan of correction does not constitute an admission of guilt or liability by the facility and is submitted only in response to the regulatory requirement. F693 Tube Feeding Management Restore Eating Skills What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; R113 was assessed and Physican was notified. Tube feeding was administered per order. How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken; All residents requiring tube feeding have the potential to be affected by the alleged deficient practice. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur; Nursing staff were educated on: · Ensuring tube feeding is administered as ordered. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance programs will be put into place;	11/08/2024

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	and had a feeding tube. A Care Plan, dated 7/29/24, indicated the resident was at risk for malnutrition (poor nutrition) and was reliant on a tube feeding for all nutrition and hydration. Interventions were to provide the tube feeding per physician's order and to monitor tube feeding tolerance. A Physician's Order, dated 2/2/24, indicated the resident had a nothing by mouth (NPO) diet. A Physician's order, dated 2/4/24, indicated to administer the tube feeding by pump via peg tube at 70 cc/hr with on time at 10:00 a.m., and off time at 6:00 a.m. The Medication Administration Record (MAR), dated 10/2024, indicated the tube feeding was signed out as turned off at 6:00 a.m. on 10/18/24. During an interview on 10/18/24 at 3:03 p.m., the Director of Nursing (DON) indicated she understood the tube feeding concern and had no additional information to add. 3.1-44(a)(2)		Nursing Managers will audit 3 residents receiving tube feeding 3 times per week to ensure formula is being administered as ordered. The Director of Nursing/designee will present a summary of the audits to the Quality Assurance committee monthly for 6 months. Thereafter, if determined by the Quality Assurance committee, auditing and monitoring will be done quarterly and present quarterly at the QA meeting. Monitoring will be on going. Date by which systemic corrections will be completed: 11/8/2024	
F 0695 SS=D Bldg. 00	483.25(i) Respiratory/Tracheostomy Care and Suctioning Based on observation, record review, and interview, the facility failed to ensure oxygen was at the correct flow rate for 1 of 1 resident reviewed for oxygen. (Resident 120) Finding includes: On 10/15/24 at 10:34 a.m. and 3:11 p.m., Resident 120 was observed in his room in bed with oxygen	F 0695	Munster Med INN Annual Survey: 10/22/2024 Please accept the following as the facility's credible allegation of compliance. This plan of correction does not constitute an admission of guilt or liability by the facility and is submitted only in response to the regulatory	11/08/2024

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	by the way of a nasal cannula in use. The oxygen concentrator was set at 3 liters. On 10/16/24 at 11:18 a.m., the resident was observed in his room in bed. His oxygen was in use and the oxygen concentrator was set at 3 1/2 liters. At 3:59 p.m., the oxygen concentrator was set at below 4 liters. On 10/17/24 at 10:12 a.m., 11:35 a.m. and 2:14 p.m., the resident was observed in his room in bed. His oxygen was in use and the oxygen concentrator was set at 3 1/2 liters. The record for Resident 120 was reviewed on 10/18/24 at 9:30 a.m. Diagnoses included, but were not limited to, dementia with behavior disturbance, psychotic disorder with delusions, chronic obstructive pulmonary disease (COPD), and oxygen dependent. The Quarterly Minimum Data Set (MDS) assessment, dated 7/11/24, indicated the resident was moderately impaired for daily decision making and he received oxygen therapy while a resident of the facility. A Care Plan, dated 2/6/24 and reviewed on 10/17/24, indicated the resident required oxygen therapy related to congestive heart failure (CHF), COPD, and a recent history of pneumonia. Interventions included, but were not limited to, oxygen via nasal cannula per physician's order. A Physician's Order, dated 4/16/24 and listed as current on the October 2024 Physician's Order Summary (POS), indicated the resident was to receive 4 liters of oxygen per nasal cannula continuously.		requirement. F695 Respiratory/Tracheostomy Care and Suctioning What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; R120's oxygen flow rate was corrected immediately. How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken; All residents requiring oxygen therapy have the potential to be affected by the alleged deficient practice. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur; Staff were educated on: · Providing oxygen at the ordered liter flow rate. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance programs will be put into place; Nursing Managers will audit 3 residents 2 times per week to ensure oxygen is set at the ordered liter flow rate. Director of Nursing/designee will present a summary of the audits to the Quality Assurance committee monthly for 6 months. Thereafter, if determined by the Quality Assurance committee,	

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	During an interview on 10/18/24 at 11:14 a.m., the Assistant Director of Nursing indicated he had been checking the resident's oxygen daily and it was set at 4 liters and he was wondering if maybe the resident was adjusting the flow rate. 3.1-47(a)(6)		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	
F 0805 SS=E Bldg. 00	483.60(d)(3) Food in Form to Meet Individual Needs Based on observation and interview, the facility failed to correctly prepare a pureed (blended smooth) diet designed to meet the needs of the residents. This had the potential to affect 10 of 10 residents who received a pureed diet. Findings include: 1. During the pureed meal observation on 10/21/24 at 10:05 a.m., Dietary Cook 1 was preparing to make pureed bread for the lunch meal. At that time, there was no recipe in front of her to view. She indicated she was making enough for 15 pureed diets, however, there were only 10 residents who had orders for a pureed meal. She removed 7 slices of bread, broke them into little pieces and placed them in the blender. She poured milk from an 8 ounce carton into a measuring cup and indicated it was about 4 ounces and proceeded to pour it into the blender. She continued to add more bread and milk for a total of 27 pieces of bread and 4 (8) ounce cartons of milk to make the pureed bread. The Food Service Manager (FSM) stood by the cook during the preparation. The recipe for pureed bread, provided by the FSM, indicated the following: 10 servings: 10 slices of bread, 3 cups of cold milk	F 0805	Munster Med INN Annual Survey: 10/22/2024 Please accept the following as the facility's credible allegation of compliance. This plan of correction does not constitute an admission of guilt or liability by the facility and is submitted only in response to the regulatory requirement. F805 Food in Form to Meet Individual Needs What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; Dietary manager immediately corrected the staff to follow the recipe for the puree bread and chicken. How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken; All residents requiring puree diets have the potential to be affected by the alleged deficient practice. What measures will be put into	11/08/2024

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	and 1/2 cup of melted margarine. 20 servings: 20 slices of bread, 1 quart and 2 cups of milk, and 1 cup of melted margarine. 2. During the pureed observation on 10/21/24 at 10:33 a.m., Dietary Cook 1 was preparing to make pureed baked chicken. The cook added 4 cups of water and 1/4 cup of chicken base to a pan on the stove to make chicken broth. She scooped out the diced baked chicken into a measuring cup and filled it up to the 4 cup mark. She added the chicken to the blender and then added 4 cups of chicken broth. She blended the mixture and poured it into a pan. There was no recipe in front of the cook and the Food Service Manager stood by the cook during the preparation. The recipe for pureed baked chicken, provided by the FSM, indicated the following: 10 servings: 2.5 pounds of diced chicken and 1 cup of chicken broth. 20 servings: 5 pounds of diced chicken and 2 cups of chicken broth. During an interview on 10/21/24 at 4:40 p.m., the Administrator indicated the dietary cook was new, however, the dietary manager should have intervened and instructed her to use the recipe. 3.1-21(a)(3)		place or what systemic changes will be made to ensure that the deficient practice does not recur; Dietary managers/dietary staff were re-educated on: · Following the recipes when preparing food including altered consistency diets How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance programs will be put into place; Dietary Manager/Designee will audit altered diets preparation 2 times per week to ensure the recipe is followed and consistency is accurate. Administrator/designee will present a summary of the audits to the Quality Assurance committee monthly for 6 months. Thereafter, if determined by the Quality Assurance committee, auditing and monitoring will be done quarterly and present quarterly at the QA meeting. Date by which systemic corrections will be completed: 11/8/2024	
F 0812 SS=F Bldg. 00	483.60(i)(1)(2) Food Procurement,Store/Prepare/Serve-Sanitary Based on observation, record review, and interview, the facility failed to keep the kitchen clean and in good repair related to dirty convection ovens, transportation carts, food preparation tables, the steam table, and the reach	F 0812	Munster Med INN Annual Survey: 10/22/2024 Please accept the following as the facility's credible allegation of compliance. This plan of	11/08/2024

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	in coolers, as well as stacking clean but wet plates and dome lids on top of each other, and improper glove usage while preparing ready to eat food for 1 of 1 kitchen. (The Main Kitchen) This had the potential to affect 154 of 155 residents who resided in the facility. Findings include: 1. During the Kitchen Sanitation Tour on 10/15/24 at 9:44 a.m., with the Food Service Manager (FSM) the following was observed: a. The sides, doors, and inside of the convection ovens were dirty with a large and heavy accumulation of grease and burned food spillage on the bottom racks. b. There was a large scoop inside the sugar bin laying directly on the sugar. c. The sides of the food preparation table and the steam table were dirty with dried food spillage. d. There were 5 open transportation carts that housed dirty trays and dishes from the units. The carts had dried food spillage all over the sides and racks. e. The freezer floor and ceiling had a large amount of ice build up with large chunks observed. f. Reach in coolers 1, 3, and 4 were dirty on the inside and outside with dried food spillage. The vent inside the coolers were dusty and dirty. During an interview on 10/15/24 at 10:15 a.m., the FSM indicated all of the above was in need of cleaning.		correction does not constitute an admission of guilt or liability by the facility and is submitted only in response to the regulatory requirement. F812 Food Procurement, Store/Prepare/Serve/Sanitary What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; Liquid spills were cleaned from floors, doors, and walls. Burn food spillage, Grease and grim was cleaned from the food preparation equipment including the convection oven, transportation carts, Food preparation tables, steam table and reach in coolers 1,3 and 4. Scoop inside sugar bin was removed bin was cleaned out and new sugar input. Plates and Dome lids dried before put away. Proper glove usage while preparing ready to eat food was complete. How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken. All residents have the potential to be affected by the alleged deficient practice. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur. Dietary manager/dietary staff were	

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	During an interview on 10/22/24 at 11:15 a.m., the Maintenance Director indicated the ice build up was probably from the plastic strips getting caught in the door or from staff not shutting the door all the way. 2. During the pureed food prep observation on 10/21/24 at 10:05 a.m., Dietary Cook 1 was observed to wash her hands with soap and water and then donned a clean pair of gloves to both hands. Using her gloved hands, she opened the bread wrapper, removed the lid from the blender and opened 2 cartons of milk. She then removed the bread from the wrapper with the same gloved hands and tore it apart and placed it inside the blender. She put the lid back on the blender with the same gloved hands and added milk to the mixture. She repeated these steps using the same gloved hands during the entire pureed bread observation. The FSM stood by the cook and observed the entire procedure. During an interview on 10/21/24 at 10:25 a.m., Dietary Cook 1 indicated she was unaware she could not touch other items with her gloved hands and then touch the bread. 3. During a random observation on 10/21/24 at 10:29 a.m., Dietary Aide 1 was observed stacking clean but wet plates, dome lids and trays on top of each other as they exited the dish machine. During an interview with the FSM at the time of the observation, she indicated the plates and dome lids should not be stacked on top of each other. She then instructed the dietary aide not to stack them.		re-educated on: • Keeping Kitchen clean of debris such as liquid spills, splashes, grease and grim build up. • Keeping convection oven/ovens clean • Cleaning Transportation carts, food preparation tables, steam table, and the reach in coolers • Keeping Kitchen floors, walls, freezer and behind equipment clean. • Dishes dried before being put away. • Kitchen sanitation • Proper drying of dishes before being stored • Proper glove usage while preparing ready to eat food How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance programs will be put into place; Administrator/Designee will audit kitchen 2 times per week to ensure cleanliness/sanitation of the kitchen areas is maintained. Administrator/designee will present a summary of the audits to the Quality Assurance committee monthly for 6 months. Thereafter, if determined by the Quality Assurance committee, auditing and monitoring will be done quarterly and present quarterly at the QA meeting. Date by which systemic corrections will be completed: 11/8/2024	

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	During an interview on 10/21/24 at 4:40 p.m., the Administrator indicated she was aware the kitchen was in need of cleaning. She also indicated the dietary cook was new, however, the FSM should have intervened and instructed her to change gloves. The current 9/2020 "Infection Control-Storage and Sanitation" policy, provided by the Administrator on 10/22/24 at 10:05 a.m., indicated staff would wash hands and arms often with soap and hot water and after handling dirty dishes, utensils, food and before handling clean dishes and food. Staff would avoid contamination by not touching milk, water, soup, butter, ice, desserts, sandwiches, salads, ice cream or any food that would not be processed further. 3.1-21(i)(3)			
F 0842 SS=D Bldg. 00	483.20(f)(5), 483.70(i)(1)-(5) Resident Records - Identifiable Information Based on record review and interview, the facility failed to ensure clinical records were complete and accurately documented related to medication orders for 1 of 6 residents reviewed for unnecessary medications and 1 of 1 resident reviewed for tube feeding. (Residents 139 and 113) Findings include: 1. The record for Resident 139 was reviewed on 10/21/24 at 9:28 a.m. Diagnoses included, but were not limited to, type 2 diabetes mellitus, hypertension, and depression. The Quarterly Minimum Data Set (MDS) assessment, dated 8/23/24, indicated the resident	F 0842	Munster Med INN Annual Survey: 10/22/2024 Please accept the following as the facility's credible allegation of compliance. This plan of correction does not constitute an admission of guilt or liability by the facility and is submitted only in response to the regulatory requirement. F842 Resident Records-Identifiable Information What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; R113's medication route orders	11/08/2024

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

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	feeding per physician's order and monitor the tube feeding tolerance. A Physician's Order, dated 2/2/24, indicated the resident had a nothing by mouth (NPO) diet. A Physician's Order, dated 5/14/24, indicated to administer Xanax (an anti-anxiety medication) oral tablet 0.25 milligram (mg) by mouth at bedtime. A Physician's Order, dated 5/14/24, indicated to administer Norco (pain pill) an oral tablet 5-325 milligram (mg) by mouth every 12 hours as needed for pain. The Medication Administration Record (MAR), indicated the oral Norco was signed out as given on 6/2/24, 6/8/24, 6/19/24 and 9/17/24. The oral Xanax was signed out as given by mouth from May 2024 through October 2024. During an interview on 10/18/24 at 3:03 p.m., the Director of Nursing indicated the orders would be changed to reflect the resident's NPO status. . 3.1-50(a)(2)		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	
F 0921 SS=E Bldg. 00	483.90(i) Safe/Functional/Sanitary/Comfortable Environ Based on observation and interview, the facility failed to keep the residents' environment clean and in good repair related to dirty floors, toilets, walls, tube feeding poles, ceiling vents, overflowing garbage cans, and debris in light fixtures. The facility also failed to keep the kitchen clean related to food splattered on walls, dirty floors, and dirty piping under the dish machine for 4 of 4 floors and 1 of 1 kitchens. (The 2nd, 3rd, 4th, 5th floors, and the main kitchen)	F 0921	Munster Med-Inn Annual Survey: 10/22/2024 Please accept the following as the facility's credible allegation of compliance. This plan of correction does not constitute an admission of guilt or liability by the facility and is submitted only in response to the regulatory requirement.	11/08/2024

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	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 did not 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 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. 5. During the Environmental Tour on 10/22/24 at		F921 Safe/Functional/Sanitary/ Comfortable 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 2,3,4, and 5. Housekeeping was also notified and has completed the cleaning needs for bathrooms, dirty floors, toilets, toilet riser, grab bars, 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 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 residents having the potential to	

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	155131	A. BUILDING 00 B. WING	10/22/2024

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	10:30 a.m., with the Director of Maintenance, the Administrator, and the Director of Housekeeping the following was observed: a. 2nd Floor - Room 214: the over bed table and the tube feeding pole had dried enteral feeding on the base. The wall behind the pole and bed was dirty with dried tube feeding spillage. The wall by the heat register had dried spillage and the heat register was dirty. The floor mats were observed with dried food spillage and tube feeding and they were torn and frayed. The entire floor in the room was dirty with black marks and stains. The hot water faucet was observed with just a trickle and not a full stream. There was lime build up around the faucets. The entire room smelled like stale urine. There were 2 residents who resided in the room and 4 shared the bathroom. - Room 215: the room door frame was gouged. - Room 216: there was debris in the bathroom light fixture. There were 4 residents who shared the bathroom. - Room 223: the floor was dirty with black scuff marks and stains. There was adhered dirty in the corners and along the baseboard. The back of the toilet where the grab bars were nailed down had dried urine, dirt, and a dried pink substance. There was 1 resident who resided in the room and 3 residents shared the bathroom. - Room 229: the floor was dirty with stains and black scuff marks. There was 1 resident who resided in the room.		be affected by the same deficient practice and what corrective action will be taken. All residents of the facility have the potential to be affected by the same alleged deficient practice. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur: Staff were educated on: ü Notifying environmental service and maintenance of any needed repairs and cleaning needs. ü Floor, vents, and residents room cleaned daily ü Keeping resident's toiletry items contained/stored properly ü Keeping kitchen cleaned How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance programs will be put into place. The housekeeping Director will audit 5 rooms and 4 hallways per week on alternating units for Cleanliness. The Maintenance Director will audit 5 rooms per week on alternating units for maintenance issues. Any issues will be corrected. Facility Angel's will audit 10 resident rooms 3 times per week to ensure personal items are contained/stored properly. The Administrator/designee will present a summary of the audits to the Quality Assurance	

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	b. 3rd Floor - Room 327: the base of the tube feeding pole had dried enteral feeding. The floor around the pole also had dried tube feeding. c. 4th Floor - Room 421: the floor was sticky throughout the room and there was garbage under both beds. d. 5th Floor - The floors located on both halls and dining room were stained, sticky, and dirty. - The chair rail in both halls was marred with black scuff marks. - Room 502: there was a urine odor in the bathroom. There were 2 residents who used the bathroom. - Room 513: the headboard was loose and the wall behind the bed was gouged with holes. The floor mat was frayed and dirty. There was a urine odor in the room. - Room 514: there was an uncontained tooth brush, tooth paste, and an emesis basin on top of mirror. There were 4 residents who shared the bathroom. - Room 517: there was paint peeling above the heating unit. There was 1 resident who resided in the room. - Room 519: there was strong urine odor in the bathroom and the toilet lift seat was discolored yellow. There was an uncontained gray wash		committee monthly for 6 months. Thereafter, if determined by the Quality Assurance committee, auditing and monitoring will be done quarterly and present quarterly at the QA meeting. Monitoring will be on going. Date by which systemic corrections will be completed: 11/8/2024	

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	basin on the floor underneath the sink. There were 4 residents who shared the bathroom. 6. During the Kitchen Sanitation Tour on 10/15/24 at 9:44 a.m., with the Food Service Manager (FSM) the following was observed: a. The entire kitchen floor, behind all of the food preparation equipment and under all of the tables, including the dish machine area was dirty with adhered dirt, dried food substances and black scuff marks. b. The walls behind the dish machine were dirty with dried food spillage and a black and orange substances. The white pvc pipes under the dish machine had a heavy accumulation of dried food spillage and dirt. The black rubber board on the back splash was peeling away from the wall. c. The walls and ceiling throughout the kitchen were observed with dried food spillage. d. There were 9 ceiling light covers that were dirty with dried food spillage and/or debris on the inside. e. The floor in the dried food storage room had a heavy accumulation of food debris, crumbs, and papers. During an interview on 10/15/24 at 10:15 a.m., the FSM indicated all of the above was in need of cleaning. This citation relates to Complaint IN00445179. 3.1-19(f)			