STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155131		î í	JILDING	ONSTRUCTION <u>00</u>	(X3) DATE SURVEY COMPLETED 10/22/2024		
	ROVIDER OR SUPPLIER R MED-INN			7935 C	ADDRESS, CITY, STATE, ZIP COD ALUMET AVE ER, IN 46321		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE	(X5) COMPLETION DATE
F 0000 Bldg. 00	This visit was for a Licensure Survey. The Investigation of Continuous Investigated to the allegated to the allegated Investigated Investi	Recertification and State This visit included the implaints IN00444806, N00445179. 1806 - Federal/state deficiencies tions are cited at F689. 1914 - Federal/state deficiencies tions are cited at F689. 179 - Federal/state deficiencies tions are cited at F689 and 180056 18131 189450 1806 - Federal/state deficiencies tions are cited at F689 and 1807 - Federal/state deficiencies tions are cited at F689 and 1807 - Federal/state deficiencies tions are cited at F689 and 1808 - Federal/state deficiencies tions are cited at F689 and 1808 - Federal/state deficiencies tions are cited at F689 and 1808 - Federal/state deficiencies tions are cited at F689.	F 00		The facility respectfully request paper compliance for this citation		

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

(X6) DATE

shanika Willhite Administrator 11/08/2024

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

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

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155124		ľ	JILDING	onstruction <u>00</u>	(X3) DATE SURVE COMPLETED 10/22/2024		
		155131	B. WI	NG		10/22	/2024
	PROVIDER OR SUPPLIE ER MED-INN	R		7935 C	ADDRESS, CITY, STATE, ZIP COD CALUMET AVE TER, IN 46321		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	DROVIDED'S BLANCE CORRECTION		(X5)
PREFIX	FIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL			PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
F 0550	483.10(a)(1)(2)(b)(1)(2)				•	
SS=D	Resident Rights/I	Exercise of Rights					
Bldg. 00		•					
	Based on observati	ion, record review, and	F 05	550	Munster Med INN		11/08/2024
	interview, the facil	ity failed to ensure each			Complaint Survey: 10/22/2024	ļ	
	resident's dignity v	vas maintained related to being			Please accept the following as		
	exposed from the o	doorway and wearing a hospital			facility's credible allegation of		
	gown while in bed	during the day for 3 of 6			compliance. This plan of		
	residents reviewed	for dignity. (Residents 91, 120,			correction does not constitute	an	
	and 92)				admission of guilt or liability by	y the	
					facility and is submitted only in	-	
	Findings include:				response to the regulatory		
					requirement.		
	1. On 10/15/24 at	10:36 a.m., 11:10 a.m. and 3:11			F550 Resident Rights/Exercis	e of	
	p.m., Resident 91 v	was observed in his room seated			Rights		
		The resident was wearing a			What corrective action(s) will l	эе	
		inence brief. The resident's			accomplished for those reside		
	bed was located ne	ear the door and the door to the			found to have been affected b		
	room was open. Th	ne resident was visible from the			deficient practice.		
	hallway.				R91's and 120's preference to)	
					wear a brief only while in roon		
	On 10/17/24 at 10:	10 a.m., the resident was again			was maintained and the curta		
	seated in his wheel	lchair in his room wearing a			was immediately closed to pro	ovide	
	shirt and his incom	tinence brief. The door to the			for privacy		
	resident's room wa	s open and he was visible from			R92's plan of care was update	ed to	
	the hallway.				reflect residents' preference to)	
					wear a facility gown while in b	ed.	
	The record for Res	ident 91 was reviewed on			R91's Plan of care was update	ed to	
	10/17/24 at 10:36 a	a.m. Diagnoses included, but			reflect the residents' preference	ce to	
	were not limited to	, Parkinson's disease, dementia			wear no pants while in room.		
	with behavior distu	urbance, and major depressive			How the facility will identify otl	ner	
	disorder.				residents having the potential	to	
					be affected by the same defic	ent	
		num Data Set (MDS)			practice and what corrective a	ction	
		9/5/24, indicated the resident			will be taken;		
		paired for daily decision making			All residents have the potentia		
		ll to moderate assistance for			be affected by the alleged def	icient	
	lower body dressin	ng.			practice.		
					What measures will be put int	၁	
I	The resident did no	ot have a current care plan	I		place or what systemic change	e s	

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SU			SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	ЛLDING	00	COMPL	ETED
		155131	B. W	ING		10/22/	2024
				CTDEET A	ADDRESS OF A STATE SID COD		
NAME OF P	ROVIDER OR SUPPLIER	8			ADDRESS, CITY, STATE, ZIP COD		
NALINIOTE	D MED INN				ALUMET AVE		
MUNSIE	R MED-INN			MUNSI	TER, IN 46321		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION
TAG	REGULATORY OF	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	related to not weari	ng pants while in his room.			will be made to ensure that the	Э	
					deficient practice does not rec	:ur;	
	During an interview	on 10/18/24 at 11:14 a.m., the			Staff were re-educated on:	·	
	Assistant Director of	of Nursing indicated the			· Providing for resident privacy	,	
	resident should hav	e had a care plan noting that			· Updating the residents'		
	he liked to wear a s	hirt and brief at times.			preferences to their plan of ca	re	
					How the corrective action(s) w		
					monitored to ensure the defici-		
	2. On 10/15/24 at 1	0:34 a.m., 11:10 a.m. and 3:11			practice will not recur, i.e., who	at	
	p.m., Resident 120	was observed in his room in			quality assurance programs w		
	bed. The resident v	vas wearing a t-shirt and an			put into place.		
	incontinence brief.	His legs were not covered, the			Facility Angel's will audit 10		
	privacy curtain was	n't pulled, and he was visible			residents 3 times per week to		
	from the hallway.				ensure privacy is maintained a	and	
					residents who prefer to always	3	
	On 10/16/24 at 11:1	8 a.m. and 3:59 p.m., the			wear gowns while in bed,		
	resident was observ	red in his room in bed. He was			preferences are updated in the	eir	
	wearing a t-shirt and	d an incontinence brief. His			plan of care.		
	legs were not cover	ed, the privacy curtain wasn't			Director of Nursing/designee v	vill	
	pulled, and he was	visible from the hallway.			present a summary of the aud	its	
					to the Quality Assurance		
		2 a.m., 11:35 a.m. and 2:14 p.m.,			committee monthly for 6 mont	hs.	
	the resident was ob	served in his room in bed. He			Thereafter, if determined by th	ie	
	was wearing a t-shi	rt and an incontinence brief.			Quality Assurance committee,	,	
		overed, the privacy curtain			auditing and monitoring will be	÷	
	wasn't pulled, and h	ne was visible from the hallway.			done quarterly and present		
					quarterly at the QA meeting.		
		a.m., the resident was			Monitoring will be on going.		
		m in bed. He was wearing a			Date by which systemic		
		tinence brief. His legs were			corrections will be completed:		
	-	vacy curtain wasn't pulled,			11/8/2024		
	and he was visible t	from the hallway.					
		dent 120 was reviewed on					
		m. Diagnoses included, but					
		dementia with behavior					
		tic disorder with delusions,					
		pulmonary disease (COPD),					
	and oxygen depend	ent.					

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

Event ID:

2HNN11 Facility ID: 000056

If continuation sheet Page 3 of 49

	Γ OF HEALTH AND HUI R MEDICARE & MEDIC						TED: 11/19/2024 RM APPROVED IB NO. 0938-039	
STATEMEN	NT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155131	A. BU	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING			(X3) DATE SURVEY COMPLETED 10/22/2024	
	NAME OF PROVIDER OR SUPPLIER MUNSTER MED-INN			7935 C	ADDRESS, CITY, STATE, ZIP COD ALUMET AVE TER, IN 46321			
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	IATE	(X5) COMPLETION DATE	
	assessment, dated 7 was moderately improved was moderately improved a gown, while in his but were not limited with dignity. During an interview Assistant Director of see if the resident with to reflect that. 3. D 10/16/24 at 10:12 a 9:35 a.m., 11:25 a.m. at 9:10 a.m. and 11: observed lying in both The record for Resi 10/17/24 at 9:58 a.m. not limited to, prote intermittent explosi pressure, post traun	mum Data Set (MDS) 7/11/24, indicated the resident paired for daily decision 5/24/24, indicated the resident ruly a brief, no other clothing or res room. Interventions included, resident to be provided of Nursing indicated he would rould want the privacy curtain recare plan would be updated ruring random observations on r.m. and 3:41 p.m., on 10/17/24 at r.m., and 2:10 p.m., and on 10/18/24 red a.m., Resident 92 was red wearing a hospital gown. dent 92 was reviewed on r. Diagnoses included, but were rein calorie malnutrition, red disorder, high blood reatic stress disorder (PTSD), ar disorder, and intellectual						

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

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

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

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

STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155131		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING (X3) DATE SURVEY COMPLETED 10/22/2024			
	PROVIDER OR SUPPLIER		7935	r address, city, state, zip cod Calumet ave Ster, in 46321	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	
F 0623 SS=A Bldg. 00	Second Floor Unit I Service was response care plans regarding gowns. During an interview Social Service Direplan for the resident gown during the day 3.1-3(t) 483.15(c)(3)-(6)(8) Notice Requireme Transfer/Discharg Based on record revialed to ensure the was notified in writh hospital for 2 of 3 rehospitalization. (Reference of the second for Reference of the sec	nts Before e riew and interview, the facility resident's Responsible Party ing related to a transfer to the esidents reviewed for esidents 7 and 16) esident 7 was reviewed on m. Diagnoses included, but type 2 diabetes, left below the eripheral vascular disease	F 0623	Munster Med INN Annual Survey: 10/22/2024 Please accept the following a facility's credible allegation of compliance. This plan of correction does not constitute admission of guilt or liability if facility and is submitted only response to the regulatory requirement. F623 Notice Requirements E Transfer/Discharge What corrective action(s) will accomplished for those reside found to have been affected deficient practice; The responsible party of Res 16 and 7 have been mailed of of the facility transfer and be policy. How the facility will identify of residents having the potentia	e an by the in Before I be I b

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING 00 COMPLETED B. WING 10/22/2024 155131 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 7935 CALUMET AVE MUNSTER MED-INN MUNSTER, IN 46321 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE the resident to be evaluated at the hospital related be affected by the same deficient to her left foot wound becoming progressively practice and what corrective action worse. will be taken: All residents that are transferred or A Nurses' Note, dated 8/8/24 at 10:15 p.m., discharged have the potential to indicated the resident was admitted to the hospital be affected by the same alleged with the diagnosis of gangrene (death of body deficient practice. tissue due to lack of blood flow) to the left foot. What measures will be put into place or what systemic changes The resident returned to the facility on 8/22/24. will be made to ensure that the deficient practice does not recur: There was no indication the State transfer form The Facility Medical Records was mailed to the resident's responsible party. Coordinator was educated to mail (Via USPS) a copy of the notice of During an interview on 10/22/24 at 3:00 p.m., the discharge including the Bed hold Director of Nursing indicated the State transfer policy to the resident's form had not been mailed to the resident's responsible party within 72 hours responsible party. of the resident's transfer and upload proof into the resident's medical record. 2. The record for Resident 16 was reviewed on How the corrective action(s) will be 10/17/24 at 10:26 a.m. Diagnoses included, but monitored to ensure the deficient were not limited to, acute cholecystitis practice will not recur, i.e., what (inflammation of the gallbladder), anxiety, and quality assurance programs will be dementia with behavior disturbance. put into place; Administrator/Designee will audit The Quarterly Minimum Data Set (MDS) weekly to ensure the notice of assessment, dated 9/13/24, indicated the resident transfer discharge including bed was cognitively impaired for daily decision hold policy is provided to residents' responsible parties upon making. transfer/discharge. A Nurses' Note, dated 8/27/24 at 2:30 p.m., The Administrator/designee will indicated the resident was observed in the hall present a summary of the audits screaming. The resident stated her chest hurt and to the Quality Assurance she couldn't breathe, she had also vomited green committee monthly for 6 months. fluid. An order was received to send the resident Thereafter, if determined by the to the emergency room for evaluation. Quality Assurance committee, auditing and monitoring will be Nurses' Notes, dated 8/27/24 at 10:33 p.m., done quarterly and present indicated the resident was admitted to the hospital quarterly at the QA meeting.

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPL	ETED
		155131	B. W	ING		10/22/	/2024
		<u> </u>		STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF P	ROVIDER OR SUPPLIER				ALUMET AVE		
MUNSTE	R MED-INN				ER, IN 46321		
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	with acute cholecys	titis.			Monitoring will be on going.		
	The resident returne	ed to the facility on 9/5/24.			Date by which systemic corrections will be completed: 11/8/2024		
	There was no indica	ation the State transfer form			1176/2021		
		esident's responsible party.					
	_	on 10/22/24 at 3:00 p.m., the					
		indicated the State transfer					
		nailed to the resident's					
	responsible party.						
	3.1-12(a)(6)(ii)						
3.1-12(a)(6)(iii) 3.1-12(a)(6)(iii)							
	3.1 12(a)(0)(iii)						
F 0656	483.21(b)(1)(3)						
SS=D	Develop/Implemer	nt Comprehensive Care Plan					
Bldg. 00							
		view and interview, the facility	F 0	656	Munster Med-Inn		11/08/2024
		omprehensive care plan was			Annual Survey: 10/22/2024		
	developed and in pla	ace for anti-anxiety f 33 resident care plans			Please accept the following as	sthe	
	reviewed. (Resident	-			facility's credible allegation of compliance. This plan of		
	reviewed. (Resident	. 137)			correction does not constitute	an	
	Finding includes:				admission of guilt or liability by		
	8				facility and is submitted only in		
	The record for Resid	dent 139 was reviewed on			response to the regulatory		
	10/21/24 at 9:28 a.n	n. Diagnoses included, but			requirement.		
	·	type 2 diabetes mellitus,			F656 Develop/Implement		
	hypertension, and de	epression.			Comprehensive Care Plan		
					What corrective action(s) will be		
		mum Data Set (MDS)			accomplished for those reside		
		/23/24, indicated the resident ely impaired and received			found to have been affected b	y tne	
		ipsychotic medications.			deficient practice; Resident 139's antianxiety		
	anti-anxicty and ant	apsychotic medications.			medication care plan was initial	ated	
	A Physician's Order	, dated 4/2/24, indicated the			How the facility will identify oth		
	resident was to rece				residents having the potential		
		aldol) gel (a hospice			be affected by the same defici		
		ation) to the wrist topically two			practice and what corrective a		
1			1		i e e e e e e e e e e e e e e e e e e e		Ī

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

Event ID:

2HNN11 Facility ID: 000056

If continuation sheet Page 7 of 49

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY			
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER		JILDING	00	COMPL		
		155131	B. WI	ING		10/22	/2024	
NAME OF I	PROVIDER OR SUPPLIE	R	•		ADDRESS, CITY, STATE, ZIP COD	_		
	ER MED-INN			7935 CALUMET AVE MUNSTER, IN 46321				
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX	(EACH DEFICIEN	NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ATE	COMPLETION	
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE	
	times a day for agit	tation and aggressive behavior.			will be taken;			
					All residents have the potential			
		dministration Record (MAR),			be affected by the same alleg	ed		
	dated 10/2024, indicated the resident had received				deficient practice.			
	the ABH gel medic	cation twice a day.			What measures will be put int			
					place or what systemic chang			
		f any current care plan for the			will be made to ensure that th			
	-	ation, agitation, or aggressive			deficient practice does not red			
	behaviors.				Clinical staff were re-educate	a on:		
	During on interest-	y on 10/21/24 at 4:41 the			Developing care plans for residents related to mediantic	20		
	_	w on 10/21/24 at 4:41 p.m., the			residents related to medicatio	ns		
	1	g (DON) indicated there was an cation use care plan and there			such anxiolytics.	vill be		
		e plan that mentioned use of			How the corrective action(s) we monitored to ensure the defic			
		as needed. There was no care						
	1	d to the anti-anxiety			practice will not recur, i.e., wh			
		r agitation or aggressive			quality assurance programs v	ılı D C		
	behaviors.	agnation of aggressive			put into place; MDS/designee will randomly	audit		
	ochaviois.				5 residents weekly to ensure			
	3.1-35(a)				plans are in place. With a spe			
	3.1 33(4)				focus on anxiolytic medication			
					MDS/designee will present a			
					summary of the audits to the			
					Quality Assurance committee			
					monthly for 6 months. Therea			
					if determined by the Quality	,		
					Assurance committee, auditin	g		
					and monitoring will be done	J		
					quarterly and present quarter	y at		
					the QA meeting. Monitoring w	-		
					on going.			
					Date by which systemic			
					corrections will be completed:			
					11/8/2024			
E 0657	400 04(! \(0\)(") (")	,						
F 0657	483.21(b)(2)(i)-(iii	•						
SS=E	Care Plan Timing	and Revision						
Bldg. 00	Događ om abase	on record review and		C = 7	Munator Mad ININI		11/00/2024	
		on, record review and ity failed to invite and hold care	F 06	03 /	Munster Med INN Annual Survey: 10/22/2024		11/08/2024	

CENTERS FOR MEDICARE & MEDICAID SERVICES						OMB NO. 0938-039	
STATEME	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MU	JLTIPLE C	ONSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	ILDING	00	COMPL	LETED
		155131	B. WI	NG		10/22	/2024
			_	STREET	ADDRESS, CITY, STATE, ZIP COD		
NAME OF	PROVIDER OR SUPPLIE	R			CALUMET AVE		
MUNST	ER MED-INN				TER, IN 46321		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	тс	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	planning conference	es for residents and/or their			Please accept the following as	s the	
	family members. T	he facility also failed to update a			facility's credible allegation of		
	care plan related to	preferences of wearing a			compliance. This plan of		
	hospital gown for 6	of 33 residents whose care			correction does not constitute	an	
	plans were reviewe	ed. (Residents 1, 9, 129, 141, 72,			admission of guilt or liability by	y the	
	and 31)				facility and is submitted only in	า	
					response to the regulatory		
	Findings include:				requirement.		
					F657 Care Plan Timing and		
	1. During random	observations on 10/15/24 at			Revision		
	2:32 p.m., on 10/16	5/24 at 3:57 p.m., and on 10/17/24			What corrective action(s) will I	ое	
	at 9:49 a.m., 11:36	a.m., and 2:08 p.m., Resident 1			accomplished for those reside		
	was observed lying in bed wearing a hospital gown.				found to have been affected b		
					deficient practice;	•	
					A care conference was sched	uled	
	The record for Resi	ident 1 was reviewed on			for resident 1, 72, 129, 31, 9,	and	
	10/17/24 at 1:35 p.:	m. Diagnoses included, but were			141.		
	not limited to, mult	tiple sclerosis, neuromuscular			Care plans were updated for		
	bladder, vascular de	ementia, major depressive			Resident's 1, 72, 129, 31, and	141	
	disorder, anemia, h	igh blood pressure, anxiety,			preferences to wear facility go		
	and pain.				while in bed.		
					How the facility will identify oth	ner	
	The 8/30/24 Quarte	erly Minimum Data Set (MDS)			residents having the potential		
	assessment indicate	ed the resident was not			be affected by the same defici	ient	
	cognitively intact a	nd was severely impaired for			practice and what corrective a	ction	
	daily decision make	ing. The resident was			will be taken;		
	dependent on staff	for dressing.			All residents have the potentia	al to	
					be affected by this alleged		
	An outdated Care F	Plan, dated 4/27/21, indicated			deficient practice.		
	the resident's family	y preferred for the resident to			What measures will be put into	0	
		n at all times when lying in bed.			place or what systemic chang	es	
					will be made to ensure that the		
	There was no curre	ent care plan indicating the			deficient practice does not rec	ur;	
	resident wished to l	be dressed in a hospital gown			Social Service was re-educate		
	during the day.				on:		
					Scheduling Quarterly/Annual	Care	
	During an interview	v on 10/18/24 at 10:25 a.m.,			Conferences.		
	_	ne had never dressed the			Ensuring the resident/Respon	sible	
	resident in regular	clothes.			Party is invited to attend the		

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

Event ID:

2HNN11

Facility ID: 000056

conference.

If continuation sheet

Page 9 of 49

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURV			SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. Bl	UILDING	00	COMPL	ETED
		155131	B. W	ING		10/22/	2024
				OTTO DET	ADDRESS STEW STATE STR COD		
NAME OF F	PROVIDER OR SUPPLIER	L			ADDRESS, CITY, STATE, ZIP COD		
AUNOTE	D MED ININ				ALUMET AVE		
MUNSIE	R MED-INN			MUNSI	TER, IN 46321		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OF	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	During an interview	on 10/18/24 at 10:35 a.m., the			Documenting Conference Dat	е	
	Second Floor Unit l	Manager indicated Social			and Attendees in the resident'		
	Service was respons	sible for updating all of the			medical record.		
	transitional care pla	ns regarding the residents			How the corrective action(s) w	ill be	
	wearing hospital go	wns into the new point click			monitored to ensure the defici		
	care computer syste				practice will not recur, i.e., who	at	
					quality assurance programs w		
	During an interview	on 10/18/24 at 10:37 a.m., the			put into place;		
	1	ctor indicated she had not had			Administrator/Designee will au	ıdit	
	time to transfer the	resident's care plan into point			care conferences scheduled for		
	click care.				the week to ensure the		
					resident/responsible party was	3	
					invited to attend and the		
	2. During a telepho	one interview on 10/16/24 at			conference is documented in t	the	
	2:28 p.m., Resident	9's son indicated he had			resident's medical record.		
	received an invitation	on to maybe 1 or 2 care			The Administrator/designee w	ill	
	conferences, but he	was working at the time the			present a summary of the aud	its	
	facility had them so	heduled and no one from the			to the Quality Assurance		
	facility had ever cal	led him to see if it could be			committee monthly for 6 mont	hs.	
	rescheduled.				Thereafter, if determined by th	ne	
					Quality Assurance committee,		
	The record for Resi	dent 9 was reviewed on			auditing and monitoring will be	,	
	10/17/24 at 4:00 p.r	n. Diagnoses included but were			done quarterly and present		
	not limited to, heart	disease, dementia with			quarterly at the QA meeting.		
		c disorder with delusions,			Monitoring will be on going.		
		sorder, chronic pain, high			Date by which systemic		
	blood pressure, and	adult failure to thrive.			corrections will be completed:		
					11/8/2024		
	1	rly Minimum Data Set (MDS)					
		d the resident was severely					
	_	on making and was dependent					
	on staff for activitie	s of daily living.					
	There was no documentation indicating the						
	resident had a care	planning conference in the last					
	year.						
	_	on 10/18/24 at 11:25 a.m., the					
		Manager indicated the office					
	downstairs sent out	the invitations for the care					

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

Event ID:

2HNN11 Facility ID: 000056

If continuation sheet Page 10 of 49

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPLETED	
		155131	B. W	ING		10/22	/2024
NAME OF T	NDOLUDED OF COMPY		1	STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF F	PROVIDER OR SUPPLIER	ζ			ALUMET AVE		
MUNSTE	R MED-INN			MUNST	ER, IN 46321		
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIE			ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX		ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION e families. The unit manager		TAG	DEFICIENC!		DATE
	^ ·	mail when the residents were					
		cated care plan meetings for					
		ot held when the family didn't					
	show up.						
	During an interview	v on 10/18/24 on 11:30 a.m., the					
	_	ector indicated there had been					
		ngs for the resident because the					
	1	up. She was unaware a care					
		d to be held even if the family					
		he resident was cognitively					
	impaired.						
	_	iew on 10/15/24 at 11:26 a.m.,					
		ated he had not had a care e since he had been at the					
	facility.	e since he had been at the					
		ident 129 was reviewed on					
	_	m. The resident was admitted to					
	1	/24. Diagnoses included, but					
		, COPD (chronic obstructive , chronic respiratory failure,					
		disease, anxiety, palliative care,					
		gen, and chronic pain.					
		-					
		ion Minimum Data Set (MDS)					
	intact for daily deci	ed the resident was cognitively					
	mace for daily deel	ision maxing.					
	There was no docum	mentation the resident had a					
		thin the first 30 days of					
	admission.						
	During an interview on 10/18/24 at 11:30 a.m., the						
		al Service Director indicated the					
		d a care plan meeting since					
	admission.						

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

Event ID:

2HNN11 Facility ID: 000056

If continuation sheet Page 11 of 49

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING	00	COMPLETED
		155131	B. WING		10/22/2024
			CER FEE	A DEDUCAC OUTS. CT. TE. TID COD	
NAME OF F	PROVIDER OR SUPPLIEF	8		ADDRESS, CITY, STATE, ZIP COD ALUMET AVE	
MUNICTE	D MED INN			TER, IN 46321	
MONSIE	MUNSTER MED-INN			1 ER, IN 4032 I	
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)	DATE
		riew on 10/15/24 at 2:51 p.m.,			
		ated she had not had a care			
	planning conference	e since she had been at the			
	facility.				
		dent 141 was reviewed on			
	_	m. The resident was admitted			
		the diagnoses of peripheral			
		y, type 2 diabetes, morbid			
	'' '	l pressure, osteoarthritis, and			
	major depressive disorder.				
	TI 0/25/24 0	1 Mili Dir Gir (MDG)			
	1	rly Minimum Data Set (MDS)			
		d the resident was cognitively			
	intact for daily deci	sion making.			
	Thomas revoca manda ave	mentation the resident had a			
		rence within the first 30 days rence first Quarterly MDS			
	assessment.	ter the first Quarterly MDS			
	assessment.				
	During an interview	v on 10/21/24 on 12:15 p.m., the			
	_	ctor indicated there had been			
	no care plan meetin				
	no care plan meetin	gs for the resident.			
	During an interview	v on 10/22/24 at 8:30 a.m.,			
	_	istant 1 indicated she received			
		ho needed care plan meetings			
		S office around the third week			
	_	hen prepared the letters for			
		s were scheduled and sent			
	_	ilies or gave them to the			
		e their own responsible party.			
	I	s responsible for inviting the			
		etings. 5. The record for			
		viewed on 10/18/24 at 9:59 a.m.			
		, but were not limited to, heart			
	_	iabetes, anemia, and high blood			

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

Event ID:

2HNN11 Facility ID: 000056

If continuation sheet

Page 12 of 49

AND PLAN OF CORRECTION DENTIFICATION NUMBER 155131 DENTIFI	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SUR			SURVEY		
MUNSTER MED-INN SIDMARY STATEMENT OF DEFICIENCIE PREFIX TAG SUMMARY STATEMENT OF DEFICIENCIE PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG PROSS.REFERENCE TO THE APPROPRIATE DURCHMONT TAG TO Guarterly Minimum Data Set (MDS) assessment, dated 87,287.24, 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 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 downstains 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 During an interview on 10/18/24 at 2:33 p.m., the Director of Nursing (DON) indicated the care plan	AND PLAN (OF CORRECTION		<u></u>				
MUNSTER MED-INN (X3) ID SLIMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION 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 for a supportive visit. There was no documentation about inviting the resident for a supportive visit. There was no documentation about inviting the resident for a supportive visit. There was no documentation to 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 11:35 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 believe or of Nursing (DON) indicated the care plan believe or of Nursing (DON) indicated the care plan believe or of Nursing (DON) indicated the care plan believe or of Nursing (DON) indicated the care plan believe or of Nursing (DON) indicated the care plan believe or of Nursing (DON) indicated the care plan believe or of Nursing (DON) indicated the care plan believe or of Nursing (DON) indicated the care plan believe or of Nursing (DON) indicated the care plan believe or of Nursing (DON) indicated the care plan believe or of Nursing (DON) indicated the care plan believe or of Nursing (DON) indicated the care plan believe or of Nursing (DON) indicated the care plan believe or of Nursing (DON) indicated the care plan believe or of Nursing (DON) indicated the care plan believe or of Nursing (DON) indicated the care plan believe or of Nursing (DON) indicated the care plan believe or of Nursing			155131	B. W	ING		10/22	/2024
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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			ut inviting the resident to his					
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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		During an interview	y on 10/18/24 at 11:25 a.m., the					
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		_						
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			_					
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Social Service Director (SSD) indicated she was unaware a care plan meeting needed to be held even if the family did not attend, and the resident was cognitively impaired. During an interview on 10/18/24 at 2:33 p.m., the Director of Nursing (DON) indicated the care plan		on when they were	scheduled.					
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		During an interview	y on 10/18/24 at 11:30 a.m. the					
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		_						
was cognitively impaired. During an interview on 10/18/24 at 2:33 p.m., the Director of Nursing (DON) indicated the care plan								
During an interview on 10/18/24 at 2:33 p.m., the Director of Nursing (DON) indicated the care plan		even if the family d	id not attend, and the resident					
Director of Nursing (DON) indicated the care plan		was cognitively imp	paired.					
Director of Nursing (DON) indicated the care plan		During an interview	y on 10/18/24 at 2:33 n.m. the					
		_	_					
meetings should have been documented once								
they were completed, and any invites should have		_						
been followed up on.		been followed up or	n.					
During an interview on 10/21/24 at 11:47 a.m. the		During an interview on 10/21/24 at 11:47 a.m. the						
SSD indicated the resident did not have a care		During an interview on 10/21/24 at 11:47 a.m., the						
plan meeting this year because he just received a								

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

Event ID:

2HNN11 Facility ID: 000056

If continuation sheet Page 13 of 49

STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155131		(X2) MULTIPLE CO A. BUILDING B. WING	onstruction <u>00</u>	(X3) DATE SURVEY COMPLETED 10/22/2024	
	OF PROVIDER OR SUPPLIE	8	7935 C	ADDRESS, CITY, STATE, ZIP COD CALUMET AVE TER, IN 46321	
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY O	STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	(X5) COMPLETION DATE
	10/18/24 at 1:26 p. were not limited to heart failure, dysph hypertension (high iron), and diabetes. The Quarterly Min assessment, dated 8 was cognitively int A Social Service P. 1:17 p.m., indicated resident to discuss There was no docu resident to her care There was no docu invited to attend her buring an interview Second Floor Unit downstairs sent out plan meetings to the email on when they buring an interview Director of Nursing meetings should had they were completed been followed up of During an interview of During an interview of During an interview of Nursing meetings should had they were completed been followed up of During an interview of During	imum Data Set (MDS) 3/16/24, indicated the resident act for daily decision making. rogress Note, dated 1/9/24 at d the staff member met with the his quarterly assessment. mentation about inviting the conference. mentation of the resident being reare conference. w on 10/18/24 at 11:25 a.m., the Manager indicated the office the invitations for the care e families and then she got an were scheduled. w on 10/18/24 at 2:33 p.m., the g (DON) indicated the care plan are been documented once ad, and invites should have in. w on 10/21/24 at 11:47 a.m., the peter indicated Resident 31 had			

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

Event ID:

2HNN11 Facility ID: 000056

If continuation sheet Page 14 of 49

i i		(X2) M			(X3) DATE	SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	A. BUILDING <u>00</u>		COMPLETED	
		155131	B. W	ING		10/22	/2024
				STREET	ADDRESS, CITY, STATE, ZIP COD	<u> </u>	
NAME OF P	PROVIDER OR SUPPLIER	S.			ALUMET AVE		
MUNSTE	R MED-INN				ΓER, IN 46321		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
F 0677	483.24(a)(2)		İ				
SS=E	ADL Care Provide	ed for Dependent Residents					
Bldg. 00							
		on, record review, and	F 0	677	Munster Med INN		11/08/2024
		ty failed to ensure dependent			Annual Survey: 10/22/2024		
		ADL (Activities of Daily			Please accept the following as	the	
		to long and dirty fingernails			facility's credible allegation of		
	and facial hair for 4	of 11 residents reviewed for			compliance. This plan of		
	ADL's. (Residents 1	1, 6, 129, and 116)			correction does not constitute	an	
					admission of guilt or liability by		
	Findings include:				facility and is submitted only in	า	
					response to the regulatory		
		bservations on 10/15/24 at 2:32			requirement.		
	*	t 3:57 p.m., on 10/17/24 at 9:49			F677 ADL Care Provided for		
		d 2:08 p.m., and on 10/18/24 at			Dependent Residents		
		1 was observed with long			What corrective action(s) will t		
	fingernails on both	hands.			accomplished for those reside		
					found to have been affected b	y the	
		dent 1 was reviewed on			deficient practice;		
	-	m. Diagnoses included, but were			R116, R1, R6, and R129 Nails	3	
		iple sclerosis, neuromuscular			were cleaned and trimmed		
		ementia, major depressive			immediately		
		gh blood pressure, anxiety,			R6 and R129 were immediate	•	
	and pain.				assisted with trimming facial h		
	The 8/20/24 Ougets	rly Minimum Data Set (MDS)			How the facility will identify oth		
		d the resident was not			residents having the potential be affected by the same defici		
		nd was severely impaired for			_		
		ng. The resident was			practice and what corrective a will be taken;	GUUH	
		for dressing, toileting, eating,			All residents requiring assistar	200	
	personal and oral hy				with ADL Care have the poten		
	personal and oral hy	, 5.0			to be affected by the same alle		
	The Care Plan, date	d 3/12/24, indicated the			deficient practice.	Jycu	
	resident had an AD				What measures will be put into	2	
					place or what systemic change		
	The CNA task secti	on under bathing, indicated			will be made to ensure that the		
		led to the resident on			deficient practice does not rec		
	10/13-10/17/24.				Nursing Staff will be educated		
					· Grooming residents' facial ha		
	During an interview	on 10/18/24 at 10:25 a.m.,			cleaning/trimming nails, and	,	
1	ı	*	1		1 5 ,		I

STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CC	ONSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPL	ETED
		155131	B. W	ING		10/22/	2024
				CENTER	ADDRESS OF A STATE OF COR		
NAME OF I	PROVIDER OR SUPPLIEF	3			ADDRESS, CITY, STATE, ZIP COD		
MUNIOTE	D MED INN				ALUMET AVE		
MUNSTE	ER MED-INN			MUNSI	TER, IN 46321		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	CNA 2 indicated sh	ne had not cut the resident's			assistance with ADL care per	plan	
	fingernails.				of care.		
	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.				How the corrective action(s) w	ill be	
					monitored to ensure the deficient		
					practice will not recur, i.e., who	at	
					quality assurance programs w	ill be	
					put into place;		
	2. During an interview on 10/16/24 at 11:30 a.m., Resident 6 indicated her fingernails were very long and in need of trimming. The nails on both hands were also dirty. The resident had a				Facility Angels will Aduit 10		
					residents 2 times weekly to		
					ensure that grooming is compl	eted	
					with ADL care with a special fo	ocus	
					on nailcare and facial hair.		
	moderate amount of facial hair on her chin, and				Director of Nursing/designee v	vill	
	wanted that cut as well.				present a summary of the aud	its	
					to the Quality Assurance		
	During random obs	servations on 10/17/24 at 9:50			committee monthly for 6 month	ns.	
	a.m., 11:36 a.m., an	nd 2:30 p.m., the resident's			Thereafter, if determined by th	е	
	fingernails were still	ll long and dirty and her facial			Quality Assurance committee,		
	hair remained to he	r chin and neck areas.			auditing and monitoring will be	;	
					done quarterly and present		
		ident 6 was reviewed on			quarterly at the QA meeting.		
		.m. Diagnoses included, but			Monitoring will be on going.		
		, atrial fibrillation, heart failure,			Date by which systemic		
		isorder, reduced mobility,			corrections will be completed:		
		e late onset, dementia with			11/8/2024		
		od pressure, and adult failure					
	to thrive.						
	` '	imum Data Set (MDS)					
		0/2/24, indicated the resident					
		act for daily decision making.					
		d substantial to maximal					
	assistance with pers	sonal hygiene.					
		ed on 8/20/24, indicated the					
	resident had an AD	L self care deficit.					
		ion under bathing, indicated					
		completed on 9/18, 9/19, 9/24,					
	9/25, 9/27-9/29, 10/	/1-10/9, 10/14 and 10/16/24.					

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

Event ID:

2HNN11 Facility ID: 000056

If continuation sheet Page 16 of 49

STREET ADDRESS. CITY. STATE ZIP COD 7935 CALUMET AVE MUNSTER, IN 46921 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG 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 was not responsible for cutting and cleaning the resident was not responsible for cutting and cleaning the resident was not responsible for cutting and cleaning the resident was not responsible for cutting and cleaning the resident bank on 10/18/24 at 11/29 a.m., Resident 129 indicated the had long and dirty fingernalis 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 11/19 a.m., the resident was observed with long and dirty fingernalis as well as a large amount of facial hair on his checks and neck area. The record for Resident 129 was reviewed on 10/17/24 at 21/35 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.	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155131	(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 10/22/2024	
PREFIX TAG REGILATORY OR LSC IDENTIFYING INFORMATION 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 11:20 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. Diagnossi included, but were not limited to, COPD (chronic obstructive pulmonary disease), chronic respiratory failure, heart failure, each and the control of the failure and the control of the failur				7935 C	ALUMET AVE		
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 checks 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 failure, heart disease, anxiety, palliative care,	PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	COMPLETION	
The 9/1/24 Admission Minimum Data Set (MDS)	1AG	There was no docur resident had been slowers and interview 2 indicated the resident had cativity department once a week. She was were long and dirty her chin. During an interview Second Floor Unit I department was not cleaning the resident 3. During an interview Resident 129 indicating fingernails that need indicated he wanted shaven. During random obs p.m., on 10/17/24 at p.m., and on 10/18/observed with long a large amount of fameck area. The record for Resi 10/17/24 at 2:15 p.1 the facility on 8/26/were not limited to, pulmonary disease) heart failure, heart of dependence on oxygeners.	mentation indicating the haved. v on 10/18/24 at 10:20 a.m. CNA dent did not refuse care and nent provided nail care for her vas unaware the resident's nails and that she had facial hair on v on 10/18/24 at 11:00 a.m., the Manager indicated the activity responsible for cutting and nt's nails. dew on 10/15/24 at 11:29 a.m., ated he had long and dirty ded to be cut. He also dia shave and liked to be clean ervations on 10/16/24 at 3:46 t 11:37 a.m., 2:25 p.m. and 3:00 24 at 9:19 a.m., the resident was and dirty fingernails as well as acial hair on his cheeks and dent 129 was reviewed on m. The resident was admitted to (24. Diagnoses included, but COPD (chronic obstructive , chronic respiratory failure, disease, anxiety, palliative care, gen, and chronic pain.	TAG	DEFICIENCE	DATE	

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

assessment indicated the resident was cognitively

Event ID:

2HNN11

Facility ID: 000056

If continuation sheet

Page 17 of 49

	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE C		(X3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING	00	COMPLETED
		155131	B. WING		10/22/2024
NAME OF F	PROVIDER OR SUPPLIEF	3		ADDRESS, CITY, STATE, ZIP COD	
MUNSTE	R MED-INN			CALUMET AVE TER, IN 46321	
(X4) ID	Т	STATEMENT OF DEFICIENCIE	ID	·	(X5)
PREFIX		ICY MUST BE PRECEDED BY FULL	PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)	DATE
	1	sion making. The resident			
	needed substantial/i personal hygiene.	maximal assist for bathing and			
	personar nygiene.				
		8/27/24, indicated the resident			
	had an ADL self ca	re 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 receive	ed 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				
	shaved.	cating the resident had been			
	snaved.				
	_	v on 10/21/24 at 11:55 p.m., the			
		Manager indicated nails were			
		facial hair was to be removed as 5/24 at 2:39 p.m., Resident 116			
		whiskers on her chin and long			
		k dirty debris underneath the			
	nails.				
	On 10/17/24 at 10:0	3 a.m., the resident had			
		n and her nails were long and			
	dirty.				
	On 10/18/24 at 9:24	4 a.m. and 11:33 a.m., the			
		red in bed and her fingernails			
	_	dirty with dark debris beneath			
	the nails.				
	On 10/21/24 at 11:5	53 a.m., the resident was			
		her fingernails were still long			
	and dirty with dark	debris under her nails.			
	The record for Resi	dent 116 was reviewed on			
		m. Diagnoses included, but			

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

Event ID:

2HNN11 Facility ID: 000056

If continuation sheet Page 18 of 49

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

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

bruising and scabbing were assessed and

Event ID:

2HNN11

Facility ID: 000056

If continuation sheet

Please accept the following as the

Page 19 of 49

STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPL	ETED
		155131	B. W	ING		10/22/	/2024
				STREET /	ADDRESS, CITY, STATE, ZIP COD		
NAME OF F	PROVIDER OR SUPPLIEF	₹			ALUMET AVE		
MUNISTE	R MED-INN				TER, IN 46321		
MONSTE	IK MED-IMM			MONSI	ER, IN 4032 I		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	monitored, and trea	tments were in place for			facility's credible allegation of		
	_	njuries for 3 of 3 residents			compliance. This plan of		
		onditions non-pressure related.			correction does not constitute	an	
	(Residents 56, 79, a	and 6)			admission of guilt or liability by	/ the	
					facility and is submitted only in	า	
	Findings include:				response to the regulatory		
					requirement.		
		1:07 a.m., Resident 56 was			F684 Quality of Care		
		m in bed. He had an area of			What corrective action(s) will t	ре	
	reddish/purple disco	oloration to the top of his left			accomplished for those reside	nts	
	hand.				found to have been affected b	y the	
					deficient practice;		
	The record for Resident 56 was reviewed on				Resident's 79 treatment was		
	10/18/24 at 10:30 a	.m. Diagnoses included, but			re-applied and care plan for		
	were not limited to,	Alzheimer's disease, anemia,			resident removing treatment ir	า	
	and type 2 diabetes				place. R56, and 6's bruises w	ere	
					assessed. MD was notified. N	ew	
		mum Data Set (MDS)			orders were obtained to monit	or	
		/20/24, indicated the resident			bruising.		
		paired for daily decision making			How the facility will identify oth	ner	
	1 -	ntial to maximum assistance			residents having the potential	to	
	with rolling left and	I right and for chair to bed			be affected by the same defici	ent	
	transfers.				practice and what corrective a	ction	
					will be taken;		
		t have a current care plan			All residents have the potentia		
	related to the bruisi	ng to his left hand.			be affected by the same allege	ed	
					deficient practice.		
	· ·	servation form, dated 10/17/24,			What measures will be put into		
		nt's skin was intact and there			place or what systemic change		
	was no documentat	ion related to bruising.			will be made to ensure that the		
					deficient practice does not rec	ur;	
		ion on 10/18/24 at 11:17 a.m.,			Nurses were re-educated on:		
	the Assistant Director of Nursing confirmed the				· Addressing and assessing		
	discoloration to the top of the resident's left hand.				changes in skin condition such	n as	
	He indicated he would get an order to monitor the				bruises, obtaining orders for		
	bruising.				treatment, and implementation	n of	
					treatment.		
	1	r, dated 10/18/24, indicated the			Assistive clinical staff were		
		nt's left hand was to be			educated on:		
	monitored every sh	ift until resolved.			· Notifying the nurse of any		

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

Event ID:

2HNN11

Facility ID: 000056

If continuation sheet

Page 20 of 49

STATEMEN	IT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPL	ETED
		155131	B. W	NG		10/22/	/2024
				CTD FET	ADDRESS CITY STATE ZID COD		
NAME OF F	ROVIDER OR SUPPLIER	8			ADDRESS, CITY, STATE, ZIP COD		
MUNICEE	D MED INN				ALUMET AVE		
MUNSTE	R MED-INN			MUNSI	ER, IN 46321		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA'	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	. =	DATE
					change in residents' skin		
					conditions.		
	 2. On 10/15/24 at 10:40 a.m., 11:07 a.m. and 3:14 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 				How the corrective action(s) w	ill be	
					monitored to ensure the deficie		
					practice will not recur, i.e., wha	at	
					quality assurance programs w	ill be	
					put into place;		
					Facility Angels/designee will		
					complete observation rounds	on	
	propelling himself	around the unit. The open area			10 residents 3 times per week	to	
	to his left upper jaw	was not covered.			ensure areas of bruising are		
					reported to the nurse.		
	The record for Resident 79 was reviewed on				Director of Nursing/designee v	vill	
	10/17/24 at 10:55 a	.m. Diagnoses included, but			present a summary of the aud	its	
	were not limited to,	dementia with behavior			to the Quality Assurance		
	disturbance, Alzhei	mer's disease with late onset,			committee monthly for 6 montl	ns.	
	anxiety, and major	depressive disorder.			Thereafter, if determined by th	е	
					Quality Assurance committee,		
		rly Minimum Data Set (MDS)			auditing and monitoring will be		
		d the resident was cognitively			done quarterly and present		
		lecision making. The resident			quarterly at the QA meeting.		
		g an open lesion other than			Monitoring will be on going.		
	ulcers, rashes, or cu	its.			Date by which systemic		
					corrections will be completed:		
		4/26/24, indicated the resident			11/8/2024		
		(history of cancer) to the left					
	-	included, but were not limited					
	to, follow facility pr	rotocols for treatment of injury.					
	-	r, dated 9/12/24, indicated the					
		vound was to be cleansed with					
		r wound cleanser and apply					
		a medication to treat skin					
	· ·	d and cover with a dry					
		shift on Monday, Tuesday,					
	Wednesday, Thursday, and Friday for 6 Weeks						
	and as needed (PRN	۱).					
		Treatment Administration					
	Record (TAR), indi	cated the treatment to the left	1				

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

Event ID:

2HNN11 Facility ID: 000056

If continuation sheet Page 21 of 49

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155131		(X2) MULTII A. BUILDI B. WING		nstruction 00	(X3) DATE : COMPL 10/22/	ETED	
	PROVIDER OR SUPPLIEI ER MED-INN	.	79	35 CA	DDRESS, CITY, STATE, ZIP COD NLUMET AVE ER, IN 46321		
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OI	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREF TA	TIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	ΤE	(X5) COMPLETION DATE
	side of the resident completed as order	s face was signed out as being ed.					
	10/10/24, indicated skin cancer to the le	ian Progress Note, dated the resident had a basal cell eft side of his face that meters (cm) by 3.5 cm x 1.0 cm.					
	indicated the reside area to the lower ja	d 8/20/24 at 1:10 p.m., nt continued to pick at the w after he was reminded not to the spread of infection.					
	Nurses' Notes, dated 9/2/24 at 3:52 p.m., indicated the resident was picking at the area to the lower jaw.						
	indicated the treatn resident's face was keep the dressing o reminded of the im	d 10/16/24 at 9:15 a.m., nent to the side of the completed but he refused to n. The resident had been portance of keeping the aide with infection but the keep it on.					
	Assistant Director of the resident did have	ov on 10/18/24 at 11:14 a.m., the of Nursing (ADON) indicated to a history of removing the jaw and he thought a care plan					
	care plan that was of the resident display repetitively scratch	56 a.m., the ADON presented a lated 10/16/24, which indicated ed anxious behaviors by ing at his wound and he was nt orders by removing his ar basis.					
		plan prior to 10/16/24 vior of the resident removing					

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

Event ID:

2HNN11 Facility ID: 000056

If continuation sheet Page 22 of 49

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

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

	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155131	(X2) MUI A. BUII B. WIN	LDING	NSTRUCTION 00	(X3) DATE : COMPL 10/22/	ETED
	PROVIDER OR SUPPLIEI	.		7935 CA	DDRESS, CITY, STATE, ZIP COD ALUMET AVE ER, IN 46321		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION			PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
TAG	his dressing on a re observations on 10/10/17/24 at 9:50 a. Resident 6 was obs and geri sleeves (properties of the properties of the prope	gular basis. 3. During random (16/24 at 11:32 a.m. and on m., 11:36 a.m., and 2:30 p.m., erved wearing short sleeves rotective skin coverings) to etimes, the resident was and purple bruised area to the re her elbow. Ident 6 was reviewed on m. Diagnoses included, but atrial fibrillation, heart failure, isorder, reduced mobility, elate onset, dementia with od pressure, and adult failure Imum Data Set (MDS) 0/2/24, indicated the resident act for daily decision making. It is substantial to maximal sonal hygiene and received and thinner) medication. Sed on 6/21/23, indicated the tential for complications alant therapy use. The observe and report adverse ruising and do a skin		TAG	DEFICIENCY		DATE
	Xarelto (an anticoa	gulant medication) 15 Eve 1 tablet by mouth one time a					

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

Event ID:

2HNN11 Facility ID: 000056

If continuation sheet Page 23 of 49

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

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

Event ID:

2HNN11 Facility ID: 000056

If continuation sheet Page 24 of 49

STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY			SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	ILDING	00	COMPL	ETED
		155131	B. WI	NG		10/22/	/2024
			<u> </u>	CTDEET A	DDDECC CITY CTATE ZID COD		
NAME OF P	ROVIDER OR SUPPLIER	L			ADDRESS, CITY, STATE, ZIP COD		
MALINIOTE	D MED INN				ALUMET AVE		
MONSIE	R MED-INN			MONSI	ER, IN 46321		
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL	1	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	matched directly to	where the arm rest was on the					
	wheelchair. Physica	l 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					
	_	was informed of the bruise					
	-	al information to provide.					
		1					
	The current 9/1/20 '	'Skin Condition Assessment					
		licy, indicated each resident					
would be observed for skin breakdown daily during care and on the assigned bath day by the							
	_	ald be promptly reported to					
	the charge nurse who would perform the detailed						
	assessment.						
	assessment.						
	3.1-37(a)						
	3.1 3 / (u)						
F 0686	483.25(b)(1)(i)(ii)						
SS=D		Prevent/Heal Pressure					
Bldg. 00	Ulcer						
	Based on observation	on, record review, and	F 0686		Annual Survey: 10/22/2024		11/08/2024
		ty failed to ensure preventative	1 00		Munster Med-Inn		11/00/2021
		ace to prevent pressure ulcers			Please accept the following as	s the	
	_	opment of a new pressure area			facility's credible allegation of		
		ear for 1 of 2 residents			compliance. This plan of		
		re ulcers. (Resident 129)			correction does not constitute	an	
		(admission of guilt or liability by		
	Finding includes:				facility and is submitted only in		
					response to the regulatory	-	
	During a random of	oservation on 10/17/24 at 2:25			requirement.	ļ	
	_	was observed up and dressed			F686 Treatment/Svcs to	ļ	
	•	own the hallway. The resident			Prevent/Heal Pressure Ulcers	ļ	
	•	y shoes and did not have his			What corrective action(s) will be		
		told the resident she would			accomplished for those reside		
		ning on his feet and instructed			found to have been affected b		
		is room. As the resident turned			deficient practice;	yuic	
	-	nd, his left ear was observed			Resident 129's skin was	ļ	
	ms wheelenair arou	nu, ms ich cai was observed			RESIDENTIZES SKIN WAS		

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

Event ID:

2HNN11 Facility ID: 000056

If continuation sheet Page 25 of 49

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPL		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	ЛLDING	00	COMPL	ETED
		155131	B. WING 10/22/202			/2024	
		l		STREET /	ADDRESS, CITY, STATE, ZIP COD	<u> </u>	
NAME OF F	PROVIDER OR SUPPLIEF	2			ALUMET AVE		
MUNISTE	R MED-INN				TER, IN 46321		
				WIGHTON	1 - 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX		CY MUST BE PRECEDED BY FULL		PREFIX	CROSS-REFERENCED TO THE APPROPRIATE		COMPLETION
TAG		R LSC IDENTIFYING INFORMATION	-	TAG	DEFICIENCY		DATE
	with dried blood behind it.				immediately assessed. Reside		
	0.404794.200				129's MD was notified, and or		
	On 10/17/24 at 3:00 p.m., the resident was				were obtained and implement		
	observed in his room wearing oxygen via a nasal				for newly identified pressure u		
		ne, he was asked to pull back			How the facility will identify oth		
	_	the area behind the ear could			residents having the potential		
	be viewed. The area behind the ear was open with both fresh and dried blood. The resident was				be affected by the same defici		
					practice and what corrective a	ction	
	asked to pull back his left ear lobe and there was				will be taken;		
	dried blood behind that ear as well. The resident indicated both areas were painful and had been				All residents with pressure ulc		
		•			have the potential to be affect	ea	
		There were no padded over the oxygen tubing to			by the same alleged deficient		
	1 ^	over the oxygen tubing to			practice.	_	
	protect his ears.				What measures will be put into		
	On 10/17/24 at 2:0/	p.m., LPN 1 was asked to asses			place or what systemic change will be made to ensure that the		
		At that time, she removed the					
		behind his ears and both	deficient practice does not recur; Nurses were re-educated on the				
		e observed. The oxygen			following:	IIE	
	l ~	around the resident's ears,			· Obtaining orders and		
	there were indentate				implementing treatment for		
	there were indentati	ions on his face.			pressure/new skin conditions.		
	During an interview	v at that time, LPN 1 indicated			Notifying MD and resident		
	_	e resident had any pressure			responsible party of new		
		ars and she would contact the			pressure/skin conditions.		
		ess and treat the wounds.			Assistive staff were re-educate	ed he	
					on:	Ju	
	The record for Resi	dent 129 was reviewed on			· Notifying the nurse immediat	elv	
		n. The resident was admitted to			when a treatment has become	-	
		24 and his diagnoses included,			soiled or detached from wound		
		d to, COPD (chronic			How the corrective action(s) w		
		ary disease), chronic			monitored to ensure the defici		
	respiratory failure,	heart failure, heart disease,			practice will not recur, i.e., wh	at	
	anxiety, palliative of	are, dependence on oxygen,			quality assurance programs w		
	and chronic pain.				put into place;		
	_				Wound nurse/designee will		
	The 9/1/24 Admiss	ion Minimum Data Set (MDS)			randomly audit 5 residents		
	assessment indicate	d the resident was cognitively			identified at risk for skin		
	intact for daily deci	sion making. The resident			breakdown and residents with		
	needed substantial/maximal assist for bathing and				existing skin breakdown to en	sure	

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

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

Event ID:

2HNN11 Facility ID: 000056

If continuation sheet Page 27 of 49

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPLETED		
		155131	B. W	ING		10/22/	/2024	
NAME OF I	PROVIDER OR SUPPLIEI	}			ADDRESS, CITY, STATE, ZIP COD			
					ALUMET AVE			
MUNSTE	ER MED-INN			MUNSTER, IN 46321				
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX	·	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	.TE	COMPLETION	
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE	
	bilateral ears as rep	_						
		ids were noted to his bilateral						
	ears and left side of the nose from the oxygen tubing. The resident was noted in some minor							
		ese 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.							
	_	v on 10/17/24 at 3:30 p.m., the						
		Manager indicated the resident						
		ent on 10/14/24 and the						
	_	e not there. She had no						
	additional informat	ion to provide.						
	The current 9/1/20	"Skin Condition Assessment						
		olicy, indicated each resident						
		for skin breakdown daily						
		the assigned bath day by the						
		uld be promptly reported to						
	_	no would perform the detailed						
	assessment.	•						
	3.1-40(a)(1)							
F 0689	483.25(d)(1)(2)							
SS=G	Free of Accident							
Bldg. 00	Hazards/Supervis	sion/Devices						
		ration, record review, and	F 00	689	Munster Med INN		11/08/2024	
		ity failed to ensure mechanical	1		Annual Survey: 10/22/2024		11/00/2027	
		for use prior to a transfer of a			Please accept the following as	s the		
	^	for 1 of 1 resident reviewed for			facility's credible allegation of			
	_	This deficient practice resulted			compliance. This plan of			
	1	during a transfer, the resident			correction does not constitute	an	1	

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	A. BUILDING <u>00</u>			ETED
		155131	B. W	ING _		10/22/	2024
			1	STREET 4	ADDRESS, CITY, STATE, ZIP COD		
NAME OF F	PROVIDER OR SUPPLIEF	₹			ALUMET AVE		
MUNSTF	R MED-INN				TER, IN 46321		
	T		1		T		
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX		ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
falling from the lift, and the resident sustaining a				admission of guilt or liability by	•		
	left femur fracture.				facility and is submitted only in	า	
					response to the regulatory		
		vation, record review, and			requirement.		
		ty failed to ensure hot water			F689 Free of Accident		
		below 120 degrees Fahrenheit			Hazards/Supervision/Devices		
		oughout the facility. (The 5th			What corrective action(s) will be		
	and 2nd floors)				accomplished for those reside		
					found to have been affected b	y the	
	Findings include:				deficient practice;		
					○ On 10/5/2024 a full house at	udit	
	A. A confidential interview indicated Resident B				of all hoyer lift pads was		
	fell from a mechanical lift when the sling straps				completed to ensure no pads		
	broke, and the resid	lent sustained a leg fracture.			any tears, rips, or worn areas.		
					· Hoyer/mechanical lift educat		
		4 p.m., Resident B was observed			including return demonstration		
	1	immobilizer was observed on			was competed with clinical sta	aff.	
	the resident's left le	g.			· The facility hot water tank		
					temperature was immediately		
		dent B was reviewed on			decreased, and the water		
	_	m. Diagnoses included, but			temperature was checked on	all	
		, displaced oblique fracture of			floors every hour x 4 hours to		
		femur, vascular dementia with			ensure levels were maintained	d	
	behavior disturband				within the appropriate range.		
	1 *	nutrition, and orthopedic			· A service call was placed to		
	aftercare.				Precision Service to check the	9	
					water heater and related		
		S assessment, dated 8/25/24,			components		
		ent was cognitively impaired for			· The facility Medical Director		
		ing and used a mechanical lift			updated, and a recommendati		
		esident was dependent on staff			was given to supply each unit	with	
		d transfers. There had been no			a thermometer to test water		
	falls since the last a	assessment.			temperature if they suspect		
		0/2/24			temperatures are too warm.	.,	
		9/3/24, indicated the resident			Thermometers were placed or	n all	
	was at risk for falls	and injury from falls.			units.		
		140/5/04 0.00			How the facility will identify oth		
		d 10/5/24 at 9:00 a.m., indicated			residents having the potential		
		noned to the resident's room.			be affected by the same defici		
The two CNA's who were in the resident's room at				practice and what corrective a	iction		

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	A. BUILDING <u>00</u>		COMPLETED	
		155131	B. W	ING		10/22/	/2024
				STREET	ADDRESS, CITY, STATE, ZIP COD		
NAME OF I	PROVIDER OR SUPPLIE	R			ALUMET AVE		
MUNISTE	ED MEDLINN				ΓER, IN 46321		
MUNSTER MED-INN			MONS	1EK, IN 40321			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIENCY MUST BE PRECEDED BY FULL			PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ATE	COMPLETION
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	that time indicated the resident fell. The CNA's				will be taken;		
	indicated the resident fell during a transfer from				All residents have the potentia	al to	
		elchair while using the			be affected by the same alleg	ed	
		e mechanical sling strap broke			deficient practice.		
		eft leg fell from the sling. The			What measures will be put into	0	
	_	aining of pain to the left leg.			place or what systemic chang	es	
	1	notified, orders were obtained			will be made to ensure that the	е	
	to send the resident to the emergency room for				deficient practice does not rec	:ur;	
	evaluation, and 911	was contacted for transport.			Staff were in-serviced on the		
					following related to mechanica	al	
	Hospital x-ray results of the left knee, dated				lifts:		
	10/5/24, indicated the resident had a new left				· Hoyer education with return		
femur fracture. The resident was identified as				demonstration			
	having severely de	mineralized bones.			· Checking hoyer pads for rips	> ,	
					tears, and worn areas		
		completed by the facility was			· Laundry staff to inspect hoye	∍r	
		investigation documentation			pads with each wash and		
		members were transferring the			document each inspection		
		chanical lift. There were no			Staff were in-serviced on the		
	_	mechanical sling prior to			following related to water		
		r. As staff started to lift the			temperatures:		
		them, the blue strap on the left			· Acceptable water temperatu	res	
		resident's leg hit the floor. The			range		
		owered to the floor. As the			· Notifying maintenance and the	ne	
		unhooked from the mechanical			administrator if the water		
		e blue straps tore. Both			temperature is below or above	e the	
		g with the transfer indicated			acceptable range.		
		re any fraying or tears to the			How the corrective action(s) w		
		g pad prior to starting the			monitored to ensure the defici		
		no documentation which			practice will not recur, i.e., wh		
		anical lift sling straps were			quality assurance programs w	ill be	
	checked prior to the	e transfer.			put into place;		
	l				Administrator/designee will		
		dent audit, dated 10/5/24,			audit/inspect 5 hoyer lift pads		
		tional mechanical lift sling was			weekly to ensure they are in g	lood	
		lamage, was taken out of			condition.		
	service, and replace	ed.			The maintenance		
	l				director/designee will check w		
	_	, staff were re-educated on the			temperature 5 times per week		
	use of the mechanical lift and maintaining slings,				alternating floors to ensure wa	ater	

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MU	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPL	ETED
		155131	B. WING 10/22/2024			2024	
				CTD FFT A	DDDEGG OFFI GTATE ZID COD		
NAME OF P	ROVIDER OR SUPPLIER	3			ADDRESS, CITY, STATE, ZIP COD ALUMET AVE		
NALINIOTE	D MED INN						
MUNSIE	R MED-INN			MUNSI	ER, IN 46321		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	тс	COMPLETION
TAG	REGULATORY OF	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	such as checking fo	r damage before use. Ongoing			temperatures are maintained		
		nical lift sling pads were			within the appropriate range.		
		taff were responsible for			The Administrator/designee w	ill	
		s when they would need to be			present a summary of the aud		
		ng was torn or frayed, the sling			to the Quality Assurance		
		of service. Staff were also to			committee monthly for 6 mont	hs.	
		ical lift slings prior to use.			Thereafter, if determined by the		
					Quality Assurance committee,		
	A Fall Interdiscipli	nary Team (IDT) Note, dated			auditing and monitoring will be		
	-	n., indicated the resident was			done quarterly and present		
		CNA's via the mechanical lift			quarterly at the QA meeting.		
	-	wheelchair. The resident had a			Monitoring will be on going.		
		e floor. Upon assessment, the			Date by which systemic		
		d of pain to the left hip. The			corrections will be completed:		
		oved and their position was			11/8/2024		
		AS arrived. The root cause of			11/0/2024		
		uring a transfer from the bed to					
		DT note did not indicate the					
		oken mechanical sling strap.					
	lan was due to a ore	oken meenamear sinig strap.					
	Physician's Orders	dated 10/11/24, indicated the					
	-	eight bearing to the left femur					
		nobilizer was to stay in place,					
		ed for hygiene and skin					
	checks.	ed for flygiene and skin					
	CHECKS.						
	A Care Plan dated	10/14/24, indicated the resident					
		plications, including changes in					
		to oblique fracture of the left					
		oding and surgical aftercare.					
	_	led, but were not limited to,					
		needs, be sure call light was					
	-	_					
	for assistance.	espond promptly to all requests					
	ioi assisialice.						
	Duning on intermi	on 10/19/24 at 2:55 CNIA					
		on 10/18/24 at 2:55 p.m., CNA					
		lent was transferred with two					
		e CNA also indicated that the					
		g was checked prior to					
	transferring the resi	dent and no frays were noted.					

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

Event ID:

2HNN11 Facility ID: 000056

If continuation sheet Page 31 of 49

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

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

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (IDENTIFICATION NUMBER) 155131		(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 10/22/2024				
	PROVIDER OR SUPPLIEI	R	STREET ADDRESS, CITY, STATE, ZIP COD 7935 CALUMET AVE MUNSTER, IN 46321					
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	ULD BE COMPLETION			
	Housekeeper 1 indivered not inspected prior to 10/5/24. Ho 10/5/2024, the slings and after the slings should inspect the sthem to dry. During paper, dated 10/202 dryer. The paper in slings were observed 10/2/24, 10/6/24, 10/17/24, and 10/20 paper indicated the damage between 10 damage between 10 damage between 10 damage between 10 damage straps prior to Laundry Supervisor was responsible for sling straps prior to Laundry Supervisor documentation coun mechanical lift sling January 2024 and 1 damage damage determined lift and through April 2024 October 2025. The audit sheets were in Supervisor to determine the su	v, on 10/22/24 at 8:35 a.m., the r indicated the laundry staff monitoring the mechanical lift and after 10/5/24. The r indicated he was not sure ld be provided to show the gs were inspected between						

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

Event ID:

2HNN11 Facility ID: 000056

If continuation sheet

Page 32 of 49

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING <u>00</u> CC			COMPL	ETED	
		155131	B. W	B. WING			10/22/2024	
				CTREET	DDDFGG CITY CTATE ZID COD			
NAME OF I	PROVIDER OR SUPPLIEF	₹			ADDRESS, CITY, STATE, ZIP COD			
MUNIOTE	D MED ININ				ALUMET AVE			
MUNSTER MED-INN				MUNSI	ER, IN 46321			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	BROWINEDIG BLAN OF CORRECTION		(X5)	
PREFIX	(EACH DEFICIENCY MUST BE PRECEDED BY FULL			PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE			COMPLETION	
TAG	REGULATORY OR LSC IDENTIFYING INFORMATION			TAG	CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		DATE	
		slings were to be inspected						
	I	y fraying or tears were noted,						
		taken out of service and						
	_	ninistrator indicated the						
	1 -	r stated the audits were being						
		the incident and she took his						
	word for it, he did not provide her with any audit							
	sheets.							
	D							
	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							
	_	dit sheets were dated 2025.						
		e may not have been wearing						
	1 -	was why the wrong lines						
		ne month of October, he did not						
	state that he or staff	f had checked them on those						
	dates.							
		policy related to the						
		not specify how often the						
	Hoyer slings were t	to be inspected.						
	A professional refe	rence, titled "Patient Lifts						
	Safety Guide," four							
	https://www.fda.go	v/files/medical%20devices/pu						
	blished/Patient-Lift	s-Safety-Guide.pdf, indicated,						
	"Examine sling a	and attachment areas for tears,						
	holes and frayed se	ams. DO NOT USE sling with						
	any signs of wear	."						
	B1. On 10/16/24 at	11:25 a.m., the hot water						
	temperature in the b	pathroom of room 517 was hot						
	-	a.m., the Maintenance						
		on the fifth floor, which was						
	_	y care unit, and checked the						
	·	The bathroom water						
	_	n 517 registered 134.5 degrees						
	_	5 a.m., the Maintenance						
	amement. At 11.3	o a.m., the mannenance						

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

Event ID:

2HNN11 Facility ID: 000056

If continuation sheet Page 33 of 49

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

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

Event ID:

2HNN11 Facility ID: 000056

If continuation sheet Page 34 of 49

STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155131		IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING (X3) DATE SUFF COMPLETE 10/22/20			ETED	
		155131	B. W	ING		10/22/	72024
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD 7935 CALUMET AVE MUNSTER, IN 46321			
(X4) ID PREFIX		STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE		(X5) COMPLETION
TAG	REGULATORY OR LSC IDENTIFYING INFORMATION			TAG	DEFICIENCY)		DATE
	registered 120.8 deg B2. On 10/16/24 at	grees Fahrenheit. t 11:36 a.m., the hot water					
	temperature in the b	oathroom 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 de	_					
	- Room 215: 136 de	_					
	- Room 216: 137 de	egrees Fanrenneit.					
	During the Environ	mental Tour, on 10/22/24 at					
		intenance Supervisor was					
		e hot water temperatures in					
		he second floor. The water					
	_	ared 114 degrees Fahrenheit.					
	_	s in random rooms on the fifth .5 degrees Fahrenheit.					
	11001 measured 114	.5 degrees ramemen.					
	_	v, on 10/22/24 at 11:00 a.m., the					
	_	visor indicated a water line					
		ediately repaired, the hot water					
	_	as turned down, and the water holding tank was 115 degrees					
	Fahrenheit.	nording tank was 113 degrees					
	This citation relates IN00444914, and I	s to Complaints IN00444806, N00445179.					
	,						
	3.1-45(a)(1) 3.1-45(a)(2)						
F 0693 SS=D	483.25(g)(4)(5) Tube Feeding Mg	mt/Restore Eating Skills					

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

Event ID:

2HNN11 Facility ID: 000056

If continuation sheet Page 35 of 49

STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) M	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPLETED	
		155131	B. WI	NG		10/22/2	2024
				STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF P	ROVIDER OR SUPPLIER				ALUMET AVE		
MUNSTE	R MED-INN		_		ΓER, IN 46321		
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	ATE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION	_	TAG	DEFICIENCY)		DATE
Bldg. 00							
		on, record review, and	F 06	593	Munster Med-Inn		11/08/2024
		ty failed to ensure enteral tube			Annual Survey: 10/22/2024		
	_	ing at the correct time through			Please accept the following a		
		nserted directly into the			facility's credible allegation of		
		n) for 1 of 1 resident reviewed			compliance. This plan of		
	for tube feeding. (R	esident 113)			correction does not constitute		
					admission of guilt or liability b	-	
	Finding includes:				facility and is submitted only i	n	
	On 10/19/24 at 0:27	a m. Davidant 112a			response to the regulatory		
	On 10/18/24 at 9:37 a.m., Resident 113 was observed lying in bed with the head of the bed				requirement.		
	(HOB) elevated. The resident's tube feeding was				F693 Tube Feeding Manager	nent	
	running at 70 milliliter/hour (ml/hr). The tube				Restore Eating Skills	ha	
	•	lated 10/17/24. Written on the			What corrective action(s) will		
	_	ith pen was a start time of			accomplished for those reside		
		end time of 6:00 a.m. At 10:09			found to have been affected be deficient practice;	by tile	
		ng dated 10/17/24 was still			R113 was assessed and Phys	cican	
		There was a new tube feeding			was notified. Tube feeding was		
		the bedside table that was			administered per order.	15	
	_	indicated a start time of 10:00			How the facility will identify ot	her	
		the tube feeding was shut off			residents having the potential		
		esident's medication pass. At			be affected by the same defic		
		feeding bottle dated 10/18/24			practice and what corrective a		
	was on and running				will be taken;		
	8				All residents requiring tube fe	edina	
	During an interview	at the time, QMA 1 indicated			have the potential to be affect	-	
	_	0:00 a.m. tube feeding for the			by the alleged deficient practi		
	day and changed ou	<u>c</u>			What measures will be put int		
		-			place or what systemic chang		
	The record for Resid	dent 113 was reviewed on			will be made to ensure that th		
	10/18/24 at 10:00 a.	m. Diagnoses included, but			deficient practice does not red	cur;	
	were not limited to,	hemiplegia (paralysis on one			Nursing staff were educated of		
	side of the body), st	roke, depression, dementia,			· Ensuring tube feeding is		
	anxiety, dysphagia ((difficulty swallowing), and			administered as ordered.		
	diabetes.				How the corrective action(s) v	vill be	
					monitored to ensure the defic	ient	
	•	mum Data Set (MDS)			practice will not recur, i.e., wh	ıat	
		/29/24, indicated the resident			quality assurance programs w	vill be	
	was severely impaired for daily decision making				put into place;		

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

Event ID:

2HNN11 Facility ID: 000056

If continuation sheet

Page 36 of 49

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

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPL	ETED
		155131	B. W	ING		10/22	2024
				STREET	ADDRESS, CITY, STATE, ZIP COD	<u> </u>	
NAME OF F	PROVIDER OR SUPPLIEF	8			ALUMET AVE		
MIINIQTE	R MED-INN				ER, IN 46321		
IVIOINGIE				IVIOINST	LIX, IIV 4002 I		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	by the way of a nasal cannula in use. The oxygen				requirement.		
	concentrator was set at 3 liters.				F695 Respiratory/Tracheostor	ny	
					Care and Suctioning		
	On 10/16/24 at 11:18 a.m., the resident was				What corrective action(s) will be		
	observed in his room in bed. His oxygen was in				accomplished for those reside		
		concentrator was set at 3 1/2			found to have been affected b	y the	
		, the oxygen concentrator was			deficient practice;		
	set at below 4 liters				R120's oxygen flow rate was		
					corrected immediately.		
		12 a.m., 11:35 a.m. and 2:14 p.m.,			How the facility will identify oth		
		served in his room in bed. His			residents having the potential		
		and the oxygen concentrator			be affected by the same defici		
	was set at 3 1/2 lite	rs.			practice and what corrective a	ction	
					will be taken;		
		dent 120 was reviewed on			All residents requiring oxygen		
		m. Diagnoses included, but			therapy have the potential to b		
		dementia with behavior			affected by the alleged deficie	nt	
		otic disorder with delusions,			practice.		
		pulmonary disease (COPD),			What measures will be put into		
	and oxygen depend	ent.			place or what systemic chang		
					will be made to ensure that the		
		mum Data Set (MDS)			deficient practice does not rec	ur;	
		/11/24, indicated the resident			Staff were educated on:		
		paired for daily decision making			· Providing oxygen at the orde	ered	
	· ·	gen therapy while a resident			liter flow rate.		
	of the facility.				How the corrective action(s) w		
		0/6/04			monitored to ensure the defici		
		2/6/24 and reviewed on	1		practice will not recur, i.e., wh		
		the resident required oxygen	1		quality assurance programs w	ıll be	
		ongestive heart failure (CHF),			put into place;		
		t history of pneumonia.			Nursing Managers will audit 3		
		led, but were not limited to,	1		residents 2 times per week to		
	oxygen via nasal cannula per physician's order.				ensure oxygen is set at the		
	A DI		1		ordered liter flow rate.		
	A Physician's Order, dated 4/16/24 and listed as		1		Director of Nursing/designee		
	current on the October 2024 Physician's Order				present a summary of the aud	IITS	
	Summary (POS), indicated the resident was to				to the Quality Assurance		
		xygen per nasal cannula			committee monthly for 6 mont		
	continuously.				Thereafter, if determined by th		
			1		Quality Assurance committee,		l

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

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

Event ID:

2HNN11 Facility ID: 000056

If continuation sheet Page 39 of 49

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

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

Event ID:

2HNN11 Facility ID: 000056

If continuation sheet Page 40 of 49

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

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

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

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

Event ID:

2HNN11 Facility ID: 000056

If continuation sheet

Page 43 of 49

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING 00 COMPLETED B. WING 10/22/2024 155131 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 7935 CALUMET AVE MUNSTER MED-INN MUNSTER, IN 46321 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE was mildly cognitively impaired and received were updated. anti-anxiety and antipsychotic medications. R139's Medication strength and dose were clarified and updated. A Physician's Order, dated 4/2/24, indicated the How the facility will identify other resident was to receive ABH residents having the potential to (Ativan/Benadryl/Haldol) gel (a hospice be affected by the same deficient medication for agitation) to the wrist topically two practice and what corrective action times a day for agitation and aggressive behavior. will be taken; All residents have the potential to There was no documented strength, dosage, or amount to give listed in the medication order. be affected by this alleged deficient practice. The Medication Administration Record (MAR), What measures will be put into dated 10/2024, indicated the resident had received place or what systemic changes the ABH gel medication twice a day. There was a will be made to ensure that the lack of any documentation of the strength, deficient practice does not recur; dosage, or amount given. Nursing staff were educated on: · Ensuring medications routes are accurate (oral, g-tube, topical, During an interview on 10/21/24 at 4:41 p.m., the Director of Nursing (DON) indicated the label on sublingual, etc.) the ABH gel medication listed the strength, · Medication orders have what dosage, and amount to give. The staff had been dose/strength is to be administering it correctly. She indicated she administered in the order. would update the Physician's Order in the How the corrective action(s) will be computer. monitored to ensure the deficient 2. The record for Resident 113 was reviewed on practice will not recur, i.e., what 10/18/24 at 10:00 a.m. Diagnoses included, but quality assurance programs will be were not limited to, hemiplegia (paralysis on one put into place; side of the body), stroke, depression, dementia, DON/designee will audit 5 anxiety, dysphagia (difficulty swallowing), and residents' medication with special diabetes. focus on complete medication orders including administration The Quarterly Minimum Data Set (MDS) route and strength/dosage to be assessment, dated 7/29/24, indicated the resident administered 2 times per week to was severely impaired for daily decision making ensure compliance. and had a feeding tube. DON/designee will present a summary of the audits to the A Care Plan, dated 7/29/24, indicated the resident Quality Assurance committee was at risk for malnutrition (poor nutrition) and monthly for 6 months. Thereafter, was reliant on a tube feeding for all nutrition and if determined by the Quality

hydration. Interventions were to provide the tube

Assurance committee, auditing

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

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

Event ID:

2HNN11 Facility ID: 000056

If continuation sheet Page 45 of 49

A. BULINS DO DENTIFICATION NUMBER 155131 NAME OF PROVIDER OR SUPPLIER 155131 NAME OF PROVIDER OR SUPPLIER OR SUP	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
MUNSTER MED-INN (X4) ID PREFIX TAG SUMMARY STATEMENT OF DEFICIENCIE PREFIX TAG Findings include: 1. During a random observation on 10/15/24 at 11:27 a.m., there were 4 residents who shared the bathroom. 3. During an interview on 10/16/24 at 11:41 a.m., room 209 was observed with dried bowel movement on the raised tollet seat and the tollet bow had just been cleaned by the back of the toilet own, had finded bowel movement on the raised tollet seat and the bathroom. During an interview on 10/16/24 at 11:55 a.m., the Director of Housekeeping from a sister facility indicated the toilet and bathroom was dirry. 4. During an interview on 10/16/24 at 2:29 p.m., a family member indicated the floors were a direct own and dirty. The resident tresided on the 2nd floor. During an interview on 10/16/24 at 2:29 p.m., a family member indicated the foors were a direct own and dirty. The resident resided on the 2nd floor. During an interview on 10/16/24 at 2:29 p.m., a family member indicated the foors were sticky and dirty. The resident resided on the 2nd floor. A During an interview on 10/16/24 at 2:29 p.m., a family member indicated the floors were sticky and dirty. The resident resided on the 2nd floor. A During an interview on 10/16/24 at 2:29 p.m., a family member indicated the floors were sticky and dirty. The resident resided on the 2nd floor. A During an interview on 10/16/24 at 2:29 p.m., a family member indicated the floors were sticky and dirty. The resident resided on the 2nd floor.	AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPL	ETED
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repaired. How the facility will identify other								
How the facility will identify other		dirty. The resident resided on the 2nd floor.				· · · · · · · · · · · · · · · · · · ·	•	
						1 · · · · · ·	ner	
		5. During the Envir	conmental Tour on 10/22/24 at			residents having the potential		

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SUF			SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	UILDING	00	COMPL	ETED
		155131	B. W	ING		10/22/	2024
		l .		CTREET	ADDRESS, CITY, STATE, ZIP COD		
NAME OF P	ROVIDER OR SUPPLIER	₹			ALUMET AVE		
MUNICEE	R MED-INN						
MONSIE	R MED-INN			MONSI	ΓER, IN 46321		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	10:30 a.m., with the	e Director of Maintenance, the			be affected by the same defici	ent	
	Administrator, and	the Director of Housekeeping			practice and what corrective a	ction	
	the following was o	bserved:			will be taken.		
				All residents of the facility have			
	a. 2nd Floor				the potential to be affected by	the	
					same alleged deficient practic	e.	
		er bed table and the tube			What measures will be put into	o	
	feeding pole had dr	ied enteral feeding on the			place or what systemic change		
	base. The				will be made to ensure that the		
	_	e and bed was dirty with dried			deficient practice does not rec	ur:	
		e. The wall by the heat register			Staff were educated on:		
		nd the heat register was dirty.			ü Notifying environmental serv	/ice	
	The floor mats were	e observed with dried food			and maintenance of any need	ed	
		eding and they were torn and			repairs and cleaning needs.		
	-	loor in the room was dirty with			ü Floor, vents, and residents r	oom	
	black marks and sta	ins. The hot water faucet was			cleaned daily		
		a trickle and not a full stream.			ü Keeping resident's toiletry ite	ems	
		ld up around the faucets. The			contained/stored properly		
		l like stale urine. There were 2			ü Keeping kitchen cleaned		
		ed in the room and 4 shared			How the corrective action(s) w		
	the bathroom.				monitored to ensure the defici	ent	
					practice will not recur, i.e., who	at	
	- Room 215: the roo	om door frame was gouged.			quality assurance programs w	ill be	
					put into place.		
		was debris in the bathroom light			The housekeeping Director wi		
		4 residents who shared the			audit 5 rooms and 4 hallways	per	
	bathroom.				week on alternating units for		
					Cleanliness.		
		or was dirty with black scuff			The Maintenance Director will		
		here was adhered dirty in the			audit 5 rooms per week on		
	_	he baseboard. The back of the			alternating units for maintenar	nce	
	_	b bars were nailed down had			issues. Any issues will be		
		d a dried pink substance. There			corrected.		
		resided in the room and 3			Facility Angel's will audit 10		
	residents shared the	bathroom.			resident rooms 3 times per we	ek	
					to ensure personal items are		
	- Room 229: the floor was dirty with stains and		contained/stored properly.				
		There was 1 resident who	The Administrator/designee will				
	resided in the room				present a summary of the aud	its	
			1		to the Quality Assurance		

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

Event ID:

2HNN11 Facility ID: 000056

If continuation sheet Page 47 of 49

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155131		ľ í	UILDING	instruction 00	(X3) DATE (COMPL 10/22/	ETED		
	PROVIDER OR SUPPLIEI ER MED-INN	R	STREET ADDRESS, CITY, STATE, ZIP COD 7935 CALUMET AVE MUNSTER, IN 46321					
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE	
TAG	b. 3rd Floor Room 327: the badried enteral feeding also had dried tube c. 4th Floor Room 421: the floor fl	or was sticky throughout the garbage under both beds. I on both halls and dining room and dirty. oth halls was marred with black was a urine odor in the ere 2 residents who used the adboard was loose and the wall gouged with holes. The floor dirty. There was a urine odor was an uncontained tooth and an emesis basin on top of 4 residents who shared the was paint peeling above the was 1 resident who resided in was strong urine odor in the oilet lift seat was discolored		TAG	committee monthly for 6 month. Thereafter, if determined by the Quality Assurance committee, auditing and monitoring will be done quarterly and present quarterly at the QA meeting. Monitoring will be on going. Date by which systemic corrections will be completed: 11/8/2024	ns. e	DATE	
	yellow. There was	an uncontained gray wash						

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Event ID:

2HNN11 Facility ID: 000056

If continuation sheet

Page 48 of 49

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

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Event ID:

2HNN11 Facility ID: 000056

If continuation sheet Page 49 of 49