STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155131	A. BUILDING 00 B. WING	12/05/2024

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

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F 0000 Bldg. 00	This visit was for a Post Survey Revisit (PSR) to the Recertification and State Licensure Survey and the Investigation of Complaints IN00444806, IN00444914, and IN00445179 completed on 10/22/24. This visit was in conjunction with the Investigation of Complaints IN00448523 and IN00448529. Complaint IN00444806 - Not corrected. Complaint IN00444914 - Not corrected. Complaint IN00445179 - Not corrected. Complaint IN00448523 - Federal/state deficiencies related to the allegations are cited at F689. Complaint IN00448529 - Federal/state deficiencies related to the allegations are cited at F689. Survey dates: December 4 and 5, 2024 Facility number: 000056 Provider number: 155131 AIM number: 100289450 Census Bed Type: SNF/NF: 152 Total: 152 Census Payor Type: Medicare: 11 Medicaid: 113 Other: 28 Total: 152	F 0000	The facility respectfully requests paper compliance for this citation.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
shanika Willhite	Administrator	12/20/2024

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

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	These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on 12/11/24.			
F 0689 SS=G Bldg. 00	483.25(d)(1)(2) Free of Accident Hazards/Supervision/Devices Based on observation, record review, and interview, the facility failed to ensure adequate supervision and assistance were provided to a dependent resident who required total assistance of staff for bed mobility for 1 of 3 residents reviewed for accidents. (Resident B) This deficient practice resulted in a fall and the resident sustained a left femur fracture. Finding includes: A confidential interview indicated Resident B fell out of bed while being repositioned with only one staff member and the resident sustained a leg fracture, the same leg that was fractured during a fall in October 2024. An additional confidential interview indicated the resident was having surgery on 12/4/24 due to re-injuring the left leg. The record for Resident B was reviewed on 12/4/24 at 1:42 p.m. Diagnoses included, but were not limited to, displaced oblique fracture of the shaft of the left femur, vascular dementia with behavior disturbance, type 2 diabetes, protein-calorie malnutrition, and orthopedic aftercare. A Fall Risk Evaluation, dated 10/11/24, indicated the resident was at high risk for falls.	F 0689	p="" paraid="1272689550" paraeid="{efc09487-2ead-4bc4-9c0c-6fbe6cc36663}{62}" munster="" med="" inn <="" span=""> Please accept the following as the facility's credible allegation of compliance. This plan of correction does not constitute an admission of guilt or liability by the facility and is submitted only in response to the regulatory requirement. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; On 12/3/2024 education was initiated regarding providing care per the residents' individualized plan of care and care card. A full-house care card audit was completed to ensure all residents had a care card in place. How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken; All residents have the potential to be affected by the same alleged deficient practice. Maintaining residents' safety when rendering	12/13/2024

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	The Significant Change Minimum Data Set (MDS) assessment, dated 10/17/24, indicated the resident was cognitively impaired for daily decision making and had range of motion (ROM) impairment to both sides of the lower extremities. The resident was dependent on staff for rolling left and right. Section J - Health Conditions, indicated the resident had a fracture related to a fall in the last six months. The resident was also receiving Physical and Occupational therapies. A Care Plan, dated 9/3/24 and reviewed on 10/17/24, indicated the resident was at risk for falls and injury from falls. Interventions included, but were not limited to, anticipate and meet needs. A Nurse's Note, dated 12/3/24 at 7:45 p.m., indicated LPN 1 was called to the room by a CNA. The CNA stated the resident slid to the floor out of the bed while staff was providing care. The resident was seen sitting on the floor on their buttocks next to their bed near the window. There were no visible injuries and no complaints of pain. The resident was not moved and an ambulance was called. At 7:47 p.m. and 7:50 p.m., attempts were made to reach the resident's family. At 7:52 p.m., ambulance staff arrived, pertinent papers were given, and report was given to the emergency room nurse. A Hospital Note, dated 12/4/24 at 7:40 a.m. and completed by the Case Manager, indicated the resident was admitted from the emergency department on 12/3/24. The resident's chief complaint was for evaluation of left leg pain after a fall or near fall at the nursing home. X-rays were obtained of the resident's left femur upon arrival to the hospital. The hospital		care with special focus on dependent residents requiring 2-person staff assistance with care Gathering needed supplies prior to beginning care How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance programs will be put into place; The DON/Designee will observe staff perform bed mobility for 5 residents weekly, that require 2-person assistance to ensure staff are positioned correctly at bedside, items are gathered prior to rendering care, and care is provided per plan of care. The Administrator/designee will present a summary of the audits to the Quality Assurance committee monthly for 6 months. Thereafter, if determined by the Quality Assurance committee, auditing and monitoring will be done quarterly and present quarterly at the QA meeting. Monitoring will be on going. Date by which systemic corrections will be completed: 12/13/2024 p="" paraid="1272689550" paraeid="{efc09487-2ead-4bc4-9c0c-6fbe6cc36663}{62}" munster="" med="" inn <="" p="">"> p="" paraid="1272689550" paraeid="{efc09487-2ead-4bc4-9c0c-6fbe6cc36663}{62}" munster="" med="" inn <="" p="">"> p="" paraid="1272689550" paraeid="{efc09487-2ead-4bc4-9c0	

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	Radiology Report pertaining to x-ray results of the left femur, dated 12/3/24, indicated the following: 1. Interval development of acute fracture of the subtrochanteric region and proximal diaphysis of the left femur (a type of hip fracture). Post surgical changes again noted. 2. Distal left femoral fracture was present on the study of 10/5/24. On 12/5/24 at 1:30 p.m., the resident's room was observed. Resident B's bed was closest to the window in the room and the bathroom was right next to the room door. The resident had a low air loss mattress (a mattress to prevent and treat pressure ulcers) and two assist rails were at the head of the bed. The fall investigation completed by the facility was dated 12/3/24 and 12/4/24. A statement obtained from QMA 1, on 12/3/24, indicated she was assisting CNA 1 with the resident. She needed more towels for care, and she went to the bathroom to get more towels. When she came out, the resident was sliding off the side of the bed. The QMA ran over and assisted the CNA in guiding the resident to the floor instead of letting them just fall. The resident complained of their knee hurting. The resident was covered up and their back was supported until the ambulance arrived. The resident was in a sitting position. A statement obtained from CNA 1, on 12/3/24, indicated the following, "Myself and another staff member went into the patient's room to provide care for the patient, while I was turning the patient to clean her the other staff member was went [sic] to get more towels while the other staff member was doing that I had the patient already turn on her left side. With her legs crossed her hands were on the side rail (enabler). The patient is on a air mattress and started to slide down. I hollered		c-6fbe6cc36663}{62}" munster="" med="" inn <="" p="">" p="" paraid="1272689550" paraeid="{efc09487-2ead-4bc4-9c0 c-6fbe6cc36663}{62}" munster="" med="" inn <="" p="">" p="" paraid="1272689550" paraeid="{a9ce3c91-69ab-4e2e-a8 8f-c75ddb46ab95}{62}" munster="" med="" inn <="" p="">" p="" paraid="1272689550" paraeid="{a9ce3c91-69ab-4e2e-a8 8f-c75ddb46ab95}{62}" munster="" med="" inn <="" p="">" p="" paraid="1272689550" paraeid="{2c92cd13-c867-4375-b1 79-6a83c98667f7}{62}" munster="" med="" inn <="" p="">"	

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	for the other staff member to come help me. I ran to her left side and with my hands and both arms myself and the other staff member lowered her to the floor slowly. Resident was sitting up next to the bed. Nurse immediately notified vital signs were taken. I asked what hurt she stated everything." (sic) During an interview, on 12/4/24 at 2:30 p.m., the Second Floor Unit Manager indicated she was aware of the resident's fall from the night before. She indicated she was told two staff members went into the room to provide care due to the resident being "care in pairs." CNA 1 and QMA 1 entered the room to provide care. During care, the QMA went to the bathroom to obtain some towels and the CNA was left at the bedside with the resident and that was when the resident rolled a little and started to slide out of the bed. The Unit Manager indicated CNA 1 was assigned to the resident and she was a "float" CNA, however, she indicated QMA 1 was familiar with the resident. During an interview, on 12/4/24 at 3:10 p.m., CNA 1 indicated she had been assigned to the resident on the evening of 12/3/24. She indicated she was a "float" CNA and worked as needed (PRN). She also indicated that she was not that familiar with the resident but she did know the resident was "care in pairs." The CNA indicated she and QMA 1 entered the room to provide care. During care, the QMA went into the bathroom to get more towels. At that time, the resident was positioned on her left side facing the window. The QMA was on the left side of the bed prior to going to the bathroom to get towels. The CNA indicated she was standing between the two beds in the room and the QMA had been standing at the left side of the bed. The CNA indicated the resident's legs were crossed and the resident started to move			

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	their leg and was observed sliding out of the bed. The CNA indicated she yelled for help and ran to the other side of the bed and helped ease the resident to the floor. The resident was in a seated position on the floor with their legs extended and staff supporting their back. During an interview, on 12/5/24 at 2:11 p.m., the Director of Nursing (DON) indicated CNA 1 had reenacted what happened and the CNA made it sound like she was on the same side of the bed as the resident. After reading the CNA's statement, she indicated the CNA was indeed on the opposite side of the bed and had to run around to the other side of the bed to assist the resident. The DON indicated the CNA should have moved to the left side of the resident's bed when the QMA went to the bathroom to get more towels. No policy was provided prior to exit. This deficiency was cited on 10/22/24. The facility failed to implement a systemic plan of correction to prevent recurrence. 3.1-45(a)(2)			
F 0805 SS=E Bldg. 00	483.60(d)(3) Food in Form to Meet Individual Needs Based on observation and interview, the facility failed to correctly prepare a pureed (blended smooth) diet designed to meet the needs of the residents. This had the potential to affect 10 of 10 residents who received a pureed diet. Finding includes: During the pureed meal observation on 12/4/24 at 9:30 a.m., the Assistant Food Service Manager	F 0805	Munster Med INN Annual PSR Survey: 12/5/2024 Please accept the following as the facility's credible allegation of compliance. This plan of correction does not constitute an admission of guilt or liability by the facility and is submitted only in response to the regulatory requirement.	12/13/2024

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	(AFSM) was preparing to make pureed broccoli for the lunch meal. At that time, there was no recipe in front of her to view. She indicated she was making enough for 10 or 15 pureed diets, however, there were only 10 residents who had orders for a pureed meal. She placed five heaping four ounce scoops of cooked broccoli into the blender and started the machine. She then added two ounces of the broth from the prepared broccoli while the machine was still blending. She removed the lid and poured the contents into a small silver pan. After completing the pureed broccoli, she read the recipe and indicated she had omitted the butter. She indicated the butter was cooked with the broccoli, so she thought that was okay. Afterwards, she walked over to the stove with a ladle and scooped out an unknown amount of butter and poured it into the pureed broccoli and whisked it together. The pureed broccoli recipe indicated, for 15 servings, add two quarts of cooked broccoli and six tablespoons of butter and blend until smooth. The recipe did not call for any type of liquid to be added. During an interview at that time, the Assistant Food Service Manager indicated the recipe was not followed as written. This deficiency was cited on 10/22/24. The facility failed to implement a systemic plan of correction to prevent recurrence. 3.1-21(a)(3)		F805 Food in Form to Meet Individual Needs What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; The dietary manager immediately corrected the staff and instructed them to follow the recipe for puree broccoli. How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken; All residents requiring puree diets have the potential to be affected by the alleged deficient practice. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur; Dietary managers/dietary staff were re-educated on: · Following the recipes when preparing food including altered consistency foods · Using the appropriate measuring utensils when measuring ingredients (no guessing or estimating measurements) · Notifying the dietary manager and/or Administrator if food items/ingredients are unavailable immediately How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance programs will be put into place;	

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			Administrator/Designee will observe food preparation 5 times per week for alternating meals to ensure food is prepared per the recipe with a special focus on altered consistency food items. Administrator/designee will present a summary of the audits to the Quality Assurance committee monthly for 6 months. Thereafter, if determined by the Quality Assurance committee, auditing and monitoring will be done quarterly and present quarterly at the QA meeting. Date by which systemic corrections will be completed: 12/13/2024	
F 0812 SS=F Bldg. 00	483.60(i)(1)(2) Food Procurement,Store/Prepare/Serve-Sanitary Based on observation, record review, and interview, the facility failed to keep the kitchen clean and in good repair related to dirty convection ovens and a reach-in cooler, as well as stacking clean but wet plates and dome lids on top of each other for 1 of 1 kitchen observed. (The Main Kitchen) This had the potential to affect 151 of 152 residents who resided in the facility and received food from the kitchen.. Findings include: During the Kitchen Sanitation Tour on 12/4/24 at 9:30 a.m., with the Assistant Food Service Manager (FSM) the following was observed: a. The doors and inside of the convection ovens were dirty with a large and heavy accumulation of	F 0812	Munster Med INN Annual PSR Survey: 12/5/2024 Please accept the following as the facility's credible allegation of compliance. This plan of correction does not constitute an admission of guilt or liability by the facility and is submitted only in response to the regulatory requirement. F812 Food Procurement, Store/Prepare/Serve/Sanitary What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; The scoops were immediately removed from the rice and flour.	12/13/2024

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	grease and burned food spillage on the inside doors. b. There was a large scoop inside the flour and rice bins laying directly on the food. c. Reach-in cooler #3 had a dirty vent on the inside. d. There were 30 domed lids and 25 plates that were stacked on top of each other and were wet. During an interview at that time, Dietary Aide 1, who was washing dishes at the time, indicated he was unaware the plates and dome lids could not be stacked on top of each other while still wet. The plan of correction audit book indicated there were no issues with cleanliness and sanitation in the kitchen on 11/20/24, 11/22/24, 11/26/24 and 11/29/24. The last audit was completed on 12/4/24 which described the above issues. During an interview on 12/4/24 at 11:00 a.m., the Administrator indicated they had a new Food Service Manger in place and the entire kitchen had been cleaned after the survey and before the plan of correction date. During an interview on 12/5/24 at 1:30 p.m., the Administrator indicated staff had cleaned the kitchen yesterday and last night, and all of the above issues were cleaned. She again indicated staff did clean the kitchen, however, she was unsure if follow up cleanings were completed. This deficiency was cited on 10/22/24. The facility failed to implement a systemic plan of correction to prevent recurrence.		On 12/4/2024 Cleaning was completed in the kitchen and oven and oven doors were cleaned, the reach in cooler was cleaned, and the dishes were re-washed, dried, and stacked appropriately. How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken. All residents have the potential to be affected by the alleged deficient practice. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur. Dietary manager/dietary staff were re-educated on: • Keeping the Kitchen clean of debris such as liquid spills, food splashes, grease and grim build up. • Keeping convection oven, oven doors, and stove tops clean • Keeping the reach in cooler clean • Dishes dried before being put away or stacking including the dome leads • Never leaving or storing the scope in food items such as the flour and rice How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance programs will be put into place; Administrator/Designee will audit	

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	3.1-21(i)(3)		kitchen 5 times per week to ensure cleanliness/sanitation of the kitchen areas is maintained. Administrator/designee will present a summary of the audits to the Quality Assurance committee monthly for 6 months. Thereafter, if determined by the Quality Assurance committee, auditing and monitoring will be done quarterly and present quarterly at the QA meeting. Date by which systemic corrections will be completed: 12/13/2024	
F 0921 SS=E Bldg. 00	483.90(i) Safe/Functional/Sanitary/Comfortable Environ Based on observation and interview, the facility failed to keep the kitchen clean related to food splattered on walls, dirty floors, and dirty drains under the dish machine for 1 of 1 kitchen. (The Main Kitchen) Findings include: During the Kitchen Sanitation Tour on 12/4/24 at 9:30 a.m., with the Assistant Food Service Manager (FSM) the following was observed: a. The entire kitchen floor, behind all of the food preparation equipment and under of the tables, including the dish machine area, was dirty with adhered dirt, dried food substances, and black scuff marks. b. The walls behind the dish machine were dirty with dried food spillage. The white drain under the dish machine had a heavy accumulation of dried food spillage and dirt. The black rubber board on	F 0921	Munster Med-INN Annual PRS Survey: 12/5/2024 Please accept the following as the facility's credible allegation of compliance. This plan of correction does not constitute an admission of guilt or liability by the facility and is submitted only in response to the regulatory requirement. F921 Safe/Functional/Sanitary/ Comfortable Environment What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice: 12/4/2024 a deep cleaning was performed in the kitchen. Food debris was cleaned from the walls, rubber bumper near backsplash, around and under the dish machine, and light covers. The	12/13/2024

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	the back splash was peeling away from the wall. c. The ceiling throughout the kitchen was observed with dried food spillage. d. There were 2 ceiling light covers that were dirty with dried food spillage and/or debris on the inside. e. The floor in the dried food storage room had a heavy accumulation of adhered dirt and debris under the shelves. The plan of correction audit book indicated there were no issues with cleanliness and sanitation in the kitchen on 11/20/24, 11/22/24, 11/26/24 and 11/29/24. The last audit was completed on 12/4/24 which described the above issues. During an interview on 12/4/24 at 11:00 a.m., the Administrator indicated they had a new Food Service Manger in place and the entire kitchen had been cleaned after the survey and before the plan of correction date. During an interview on 12/5/24 at 1:30 p.m., the Administrator indicated staff had cleaned the kitchen yesterday and last night, and all of the above issues were cleaned. She again indicated staff did clean the kitchen, however, she was unsure if follow up cleanings were completed. This deficiency was cited on 10/22/24. The facility failed to implement a systemic plan of correction to prevent recurrence. 3.1-19(f)		Floor and shelves in the dry food pantry were cleaned. The kitchen vents were cleaned and stained ceiling tiles were replaced. How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken. All residents of the facility have the potential to be affected by the same alleged deficient practice. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur: Staff were re-educated on: Maintaining the overall cleanliness of the kitchen including: · Kitchen walls · Keeping kitchen floor as well as floor of the walk in cooler and dry food pantry clean · Cleaning shelving and cabinets · Notifying maintenance of stained ceiling tiles for replacement · Cleaning food debris and liquid splashes from light fixtures · Cleaning the floor around and under the dish machine · Adhering to the cleaning task as assigned How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance programs will be put into place. Administrator/Designee will audit kitchen 5 times per week to ensure cleanliness/sanitation of	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155131	A. BUILDING 00 B. WING	12/05/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
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			the kitchen areas is maintained. The Administrator/designee will present a summary of the audits to the Quality Assurance committee monthly for 6 months. Thereafter, if determined by the Quality Assurance committee, auditing and monitoring will be done quarterly and present quarterly at the QA meeting. Monitoring will be on going. Date by which systemic corrections will be completed: 12/13/2024	