STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155131		(X2) MULTIPLE CO A. BUILDING B. WING	00	(X3) DATE SURVEY COMPLETED 11/20/2023	
	ROVIDER OR SUPPLIER		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 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 0000 Bldg. 00	This visit was for a Licensure Survey. The Investigation of Control Investigation of Complaint Investigation Investigation Investigation of Complaint Investigation of	Recertification and State This visit included the mplaints IN00418486, 420482, and IN00420643.  6486 - Federal/state deficiencies tions are cited at F684 and  6836 - Federal/state deficiencies tions are cited at F677.  6482 - No deficiencies related to ited.  6643 - Federal/state deficiencies tions are cited at F684, F686,  6mber 14, 15, 16, 17, and 20,  60056 55131 689450	F 0000	The Facility respectfully asks desk review.	

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

TITLE (X6) DATE

shanika willhite Administrator 12/14/2023

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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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155131		A. BU	(X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING		(X3) DATE SURVEY COMPLETED 11/20/2023		
	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 APPROPRI DEFICIENCY)	IATE	(X5) COMPLETION DATE
	accordance with 410 Quality review com	0 IAC 16.2-3.1.					
F 0554 SS=D Bldg. 00	§483.10(c)(7) The medications if the defined by §483.2 that this practice is	nin Meds-Clinically Appropright to self-administer interdisciplinary team, as 1(b)(2)(ii), has determined sclinically appropriate.					
	Based on observation, record review, and interview, the facility failed to ensure residents had Physician's Orders for medications and an assessment to self-administer their own medications for 1 of 1 residents reviewed for self-administration of medication. (Resident 146)  Finding includes:  On 11/16/23 at 3:10 p.m., Resident 146's room was observed. At that time, there was a box of Ivizia eye drops on the over bed table. The resident was not in her room.  On 11/17/23 at 7:46 a.m., the resident was observed in bed eating breakfast. At that time, there was a box of Ivizia eye drops on the over bed table. The resident indicated she put the eye drops in her eyes when she needed them.		F 05	554	Munster Med INN Annual Survey: 11/20/2023  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		12/04/2023
					response to the regulatory requirement. F554 Resident Self Admin Meds-Clinically Appropriate What corrective action(s) w be accomplished for those	)	
					residents found to have bee affected by the deficient practice; A self-administration of media assessment was completed f	cation for	
	11/16/23 at 1:25 p.r. not limited to, hype disease, type 2 diab	dent 146 was reviewed on n. Diagnoses included, but were rtensive chronic kidney etes, end stage renal disease, l dialysis, acute kidney failure, edema.			resident 146. The physician was notified, and orders were obtained for lvizia eye drops and for resto self-administer eye drops. How the facility will identify other residents having the potential to be affected by the notifical forms.	ained esident	
	assessment indicate	y Minimum Data Set (MDS) d the resident was cognitively s vision was adequate with a			same deficient practice and what corrective action will be taken:		

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 11/20/2023 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 corrective lens. She had no oral problems, All facility residents with weighed 122 pounds, and has had a significant medication orders have the weight loss. The resident received dialysis as a potential to be affected by the resident. same alleged deficient practice. What measures will be put into There was no Physician's Order for the Ivizia eye place or what systemic drops, nor was there a self-administration changes will be made to assessment for the resident to administer her own ensure that the deficient eye drops. practice does not recur; Staff were educated on not leaving Interview with the Second Floor Unit Manager medications at resident bedside (UM) on 11/17/23 at 8:45 a.m., indicated she was unless there is an order for unaware the resident had eye drops in her room. self-administration and a self-administration assessment Interview with the Second Floor UM on 11/17/23 completed. at 3:20 p.m., indicated she asked the resident How the corrective action(s) where she got the eye drops from and she told her will be monitored to ensure the at the eye doctor. She used the eye drops when deficient practice will not she needed them for her dry eyes. The UM called recur, i.e., what quality the eye doctor and asked about the eye drops and assurance programs will be put they indicated they did give them to her and they into place; were to be used as needed for dry eyes. Facility Angel's will audit 10 residents 3 days per week to The current 9/1/2020 "Medication Storage" policy, ensure no medication is provided by the Assistant Director of Nursing on improperly stored at the bedside 11/17/23 at 3:23 p.m., indicated the facility should and any medication noted at not administer bed side medications without a bedside has orders for Physician's Order. The medications should be self-administration. stored in a locked compartment within the The Director of Nursing/designee resident's room. will present a summary of the audits to the Quality Assurance 3.1-11(a) committee monthly for 4 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.

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Event ID:

85IL11

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Date by which systemic

If continuation sheet Pac

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

PRINTED: 12/20/2023 FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155131		(X2) MULTIPLE CONSTRUCTION       (X3) DATE SURV         A. BUILDING       00       COMPLETEI         B. WING       11/20/202			LETED		
	PROVIDER OR SUPPLIER		7	935 CA	DDRESS, CITY, STATE, ZIP COD ALUMET AVE ER, IN 46321		
(X4) ID PREFIX	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL	PRI	D EFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPR	IATE	(X5) COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION	T	AG	corrections will be complete 12/4/2023	ed:	DATE
F 0656 SS=D Bldg. 00	§483.21(b) Comprig 483.21(b) (1) The implement a comprehent a comprehent acomprehensive as comprehensive as following -  (i) The services the attain or maintain practicable physic psychosocial well-§483.24, §483.25  (ii) Any services the required under §4 but are not provide exercise of rights the right to refuse (6).  (iii) Any specialize rehabilitative service provide as a result recommendations the findings of the its rationale in the (iv)In consultation resident's represe (A) The resident's desired outcomes	n, nursing, and mental and dis that are identified in the issessment. The ire plan must describe the at are to be furnished to the resident's highest al, mental, and being as required under or §483.40; and nat would otherwise be 83.24, §483.25 or §483.40 and due to the resident's under §483.10, including treatment under §483.10(c) discribes or specialized ces the nursing facility will to f PASARR. If a facility disagrees with PASARR, it must indicate resident's medical record. with the resident and the intative(s)-goals for admission and					

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

Event ID:

85IL11

Facility ID: 000056

If continuation sheet

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AND PLAN OF CORRECTION    DENTIFICATION NIMBER   156131   151311   15131   15131   15131   15131   15131   151	STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	JLTIPLE CO	ONSTRUCTION	(X3) DATE	SURVEY
MUNSTER MED-INN  (X4) ID SUMMARY STATEMENT OF DEFICIENCIE (IACH IDEFICIENCY MIST III EPICCIDED BY PRIETY TAG EXCELLERS FOR A COMPLETION DATE  Munster the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, must (III) Be culturally-competent and trauma-informed.  Based on record review and interview, the facility failed to initiate Care Plans related to pressure ulcers and medication use for 2 of 33 residents whose Care Plans were reviewed. (Residents N and 12)  Findings include:  1. The record for Resident N was reviewed on 11/16/23 at 2:23 p.m. Diagnoses included, but were not limited to, pullilative care, dementia with behavior disturbance, and peripheral vascular disease (PVD).  The Quarterly Minimum Data Set (MDS) assessment, dated \$8/15/23\$, indicated the resident was moderately impaired for daily decision making. The resident required extensive assistance for bed mobility.  The "Wound Rounds" Progress Notes indicated the resident was shight and or estable pressure ulcer to the right ulcers.  10/30/23 Unstageable (full-thickness pressure injuries in which the base was obscured by slough and/or estable pressure ulcer to the right ulcers.	AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPI	LETED
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- 10/30/23 Unstageable (full-thickness pressure injuries in which the base was obscured by slough and/or eschar) pressure ulcer to the right Resident N's – Care plan was implemented related to pressure ulcers.							anu	
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slough and/or eschar) pressure ulcer to the right ulcers.						1		
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		1 -						

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Event ID:

85IL11

Facility ID: 000056

If continuation sheet

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PRINTED: 12/20/2023 FORM APPROVED

DEPARTMENT OF HEALTH AND HUMAN SERVICES OMB NO. 0938-039 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 11/20/2023 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 other residents having the - 10/31/23 Stage 2 (open wound) pressure ulcer to potential to be affected by the the left posterior upper thigh. same deficient practice and what corrective action will be - 11/10/23 Deep Tissue Injury (purple or maroon taken: localized area of discolored intact skin or blood All residents have the potential to filled blister) to the right heel. be affected by the same alleged deficient practice. - 11/10/23 Deep Tissue Injury to the left upper What measures will be put into buttock. place or what systemic changes will be made to The current Care Plan did not address the ensure that the deficient resident's pressure ulcers. practice does not recur; Clinical staff were re-educated on Interview with the Assistant Director of Nursing completing care plans for (ADON) on 11/17/23 at 3:00 p.m., indicated the residents related to medications resident's pressure ulcers should have been and skin conditions timely. addressed on the current Care Plan. 2. The record How the corrective action(s) for Resident 12 was reviewed on 11/16/23 at 9:37 will be monitored to ensure the a.m. The resident was admitted to the facility on deficient practice will not 7/26/23 from the hospital. Diagnoses included, recur, i.e., what quality but were not limited to, type 2 diabetes, assurance programs will be put Parkinson's disease, stroke, dementia with other into place; behavioral disturbance, urinary tract infections, MDS/designee will randomly audit obstructive uropathy, chronic kidney disease, and 10 residents weekly to ensure major depressive disorder. care plans are in place. With a special focus on anticoagulant, The Quarterly Minimum Data Set (MDS) antipsychotics, antidepressant, assessment, dated 10/9/23, indicated the resident and pressure ulcer care plans. was moderately impaired for decision making and MDS/designee will present a had no behaviors. The resident had an indwelling summary of the audits to the foley catheter and received antipsychotic, Quality Assurance committee antidepressant, and antiplatelet medications. monthly for 4 months. Thereafter,

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There were no Care Plans for the antipsychotic,

antidepressant, and antiplatelet medications.

Physician's Orders, dated 10/10/23, indicated

Trazodone (an antidepressant medication) 150

milligrams (mg) daily, aspirin (an antiplatelet

Event ID:

85IL11

Facility ID: 000056

be on going.

If continuation sheet

if determined by the Quality

and monitoring will be done quarterly and present quarterly at

Assurance committee, auditing

the QA meeting. Monitoring will

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155131		(X2) MULTIPLE C A. BUILDING B. WING			
	ROVIDER OR SUPPLIER		7935 (	CADDRESS, 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 APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
F 0677 SS=E Bldg. 00	(an antipsychotic materies with the State of the MDS department on 11/17/23 at 10:00 medications on the have had a Care Plate of State of the MDS department on 11/17/23 at 10:00 medications on the have had a Care Plate of State	MDS assessments should in.  In the diameter of	F 0677	Munster Med INN Annual Survey: 11/20/2023  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.  F677 ADL Care Provided for Dependent Residents What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;	12/04/2023 sthe an the in

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

Event ID:

85IL11

Facility ID: 000056

If continuation sheet

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPLI	ETED
		155131	B. W	ING		11/20/2	2023
				CTREET	ADDRESS CITY STATE ZID COD		
NAME OF I	PROVIDER OR SUPPLIE	R			ADDRESS, CITY, STATE, ZIP COD		
MUNICE	D MED INN				ALUMET AVE		
MUNSTE	ER MED-INN			MUNS	ΓER, 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	REGULATORY O	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	112	DATE
	the brown substance	ce remained underneath the			Assistance with grooming		
	resident's fingernai	ls			including nail care and shavin	ıg	
					was provided to residents E,	G, B,	
	The record for Res	ident E was reviewed on			and F.		
	11/16/23 at 9:51 a.	m. Diagnoses included, but			How the facility will identify		
	were not limited to	, stroke, dementia with other			other residents having the		
	behavior disturbance, major depressive disorder,				potential to be affected by the	ne	
	and chronic kidney disease Stage 3.				same deficient practice and		
	and one maney arease stage st				what corrective action will b	е	
	The Quarterly Min	imum Data Set (MDS)			taken;		
	assessment, dated 9/11/23, indicated the resident				All dependent residents have	the	
	was moderately impaired for daily decision				potential to be affected by the	;	
	making, required moderate assistance with				same alleged deficient practic	ce.	
	personal hygiene, a	and was dependent on staff for			What measures will be put in	nto	
	bathing.				place or what systemic		
					changes will be made to		
	The resident had re	eceived a complete bed bath on			ensure that the deficient		
	11/4, 11/6, 11/7, 11	1/8, 11/12, 11/13, and 11/15/23.			practice does not recur;		
					Staff were re-educated on		
	A partial bed bath	was given on 11/10 and			providing dependent resident	s with	
	11/14/23.				assistance with Activities of D	aily	
					Living (ADL's) including shavi	ing	
	Nail care was docu	mented as being completed on			and nail care.		
		1/9, 11/12, and 11/13/23. Nail care			How the corrective action(s)	)	
	was also document	red as being completed on			will be monitored to ensure	the	
	11/15/23 at 10:08 a	a.m.			deficient practice will not		
					recur, i.e., what quality		
		Assistant Director of Nursing			assurance programs will be	put	
		3 p.m., indicated the resident's			into place;		
		been cleaned during care.			Facility Angel's will Audit 10		
		2 p.m., on 11/15/23 at 10:48 a.m.			residents weekly, to ensure		
	_	11/16/23 at 9:15 a.m. and 1:50			assistance with ADL's is being	g	
	p.m., and on 11/17/23 at 8:04 a.m. and 9:33 a.m.,				provided with a special focus	on	
		served in bed. At those times			shaving and nail care.		
	the resident had los	ng gray facial hair under their			Director of Nursing/designee		
	chin.				present a summary of the aud	dits	
					to the Quality Assurance		
		ident G was reviewed on			committee monthly for 4 mon		
	_	m. Diagnoses included, but were			Thereafter, if determined by t	he	
	not limited to, mul	not limited to, multiple sclerosis, vascular			Quality Assurance committee	,	

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY A. BUILDING 00 COMPLETED					
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER 155131	A. BU B. WI		<u>UU                                   </u>	COMPLETED 11/20/2023	
		100101	D. W1	_		11/20/2020	
NAME OF F	PROVIDER OR SUPPLIER	3			ADDRESS, CITY, STATE, ZIP COD		
MUNSTE	ER MED-INN				ER, IN 46321		
(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 DEFICIENCY)		1
TAG		R LSC IDENTIFYING INFORMATION pressive disorder, mood		TAG	auditing and monitoring will be	DATE	
		a, hammer toes for left and right			done quarterly and present		
		rmity, pain in the toes, fecal		quarterly at the QA meeting.			
	impaction, constipa				Monitoring will be on going.		
	The 9/14/23 Quarte	erly Minimum Data Set (MDS)			Date by which systemic		
	assessment, indicated the resident was severely impaired for decision making and had short and long term memory problems. The resident needed				corrections will be complete	d:	
					12/4/2023		
		h 2 person physical assist for					
	bed mobility and toileting, and an extensive assist with a 1 person physical assist for personal						
	hygiene, dressing and eating. The resident was						
		ent of bowel and was not on a					
	bowel toileting prog	gram.					
	A Care Plan, revise	d on 9/1/23, indicated the					
		s in self care. The approaches					
	provide assistance t	to the extent needed for					
	mobility, dressing,	eating, toileting, personal					
	hygiene, oral care a	and bathing.					
		mentation the resident rejected					
	or refused care for p	personal hygiene.					
	The task documenta	ation indicated the resident					
	received a complete	ed bed bath on 11/9, 11/10,					
	11/11, 11/12, and 1	1/14/23.					
	Interview with the S	Second Floor Unit Manager on					
	11/17/23 at 8:40 a.r	m., indicated the resident does					
		their facial hair should have					
		n 11/15/23 at 10:36 a.m.,					
		erved with long dirty					
	tingernails. The res	ident indicated they had been					
	cut once.						
		24 a.m., the resident's fingernails					

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	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	r í		ONSTRUCTION	(X3) DATE	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER  155131	A. BU B. W	JILDING ING	00	COMPI 11/20	
		100101	D. W			11/20	12023
NAME OF P	ROVIDER OR SUPPLIEF	₹			ADDRESS, CITY, STATE, ZIP COD ALUMET AVE		
MUNSTE	R MED-INN				FER, IN 46321		
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	· ·	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION
TAG	crumbs and stains of	R LSC IDENTIFYING INFORMATION		TAG			DATE
	Resident F's record	was reviewed on 11/15/23 at					
	11:03 a.m. Diagnos	ses included, but were not					
	limited to, dementia, Parkinson's, anemia,						
	hypertension (high blood pressure), seizure						
	disorder, malnutrition, and insomnia (difficulty						
	sleeping).						
	The Quarterly Minimum Data Set (MDS)						
	assessment, dated 9/19/23, indicated the resident						
	was moderately impaired for daily decision						
	making. The reside	nt required partial/moderate					
		eting, upper and lower body					
	-	ng. Oral hygiene required					
	-	hing and eating required set					
	up/clean up.						
	A Care Plan, dated	9/19/23, indicated the resident					
		cit with ADLs including bed					
		ansfers, and toileting.					
	Interventions include	ded, but were not limited to,					
	assist with bed mob	oility, eating, transfers, and					
	toileting as needed.						
	A Murce's Note dat	ted 9/19/23 at 9:04 a.m.,					
		nt required assistance with					
	ADLs related to Pa	-					
	Nail care was last p	provided on 10/20/23.					
	Interview with the	Assistant Director of Nursing					
		23 at 1:44 p.m., indicated the					
	resident needed the	•					
	4 On 11/15/22 of 2	·28 n m Resident P wes					
	4. On 11/15/23 at 2:38 p.m., Resident B was observed with several light gray whiskers on their						
	chin.	iai iigiit gray wiiiskeis oii tiicii					
	On 11/16/23 at 10-4	56 a m. Resident B was					

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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  11/20/2023		
	PROVIDER OR SUPPLIER		7935 C	ADDRESS, CITY, STATE, ZIP COI ALUMET AVE FER, IN 46321	)	
(X4) ID PREFIX	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APP	JLD BE	(X5) COMPLETION
TAG	observed laying in l	Ded, and the whiskers were still The resident expressed they	TAG	DEF[CIENCY]		DATE
	3:39 p.m. Diagnose to, dementia, heart	was reviewed on 11/17/23 at s included, but were not limited failure, hypertension (high kiety and depression.				
	assessment, dated 1 was cognitively into	mum Data Set (MDS) 0/3/23, indicated the resident act for daily decision making and lower body limitations and				
	had a self care performance including bed mobil toileting. Intervention	11/1/23, indicated the resident ormance deficit with ADLs lity, eating, transfers, and ons included, but were not th bed mobility, eating, ing as needed.				
		Assistant Director of Nursing 23 at 9:35 a.m., indicated she mation to provide.				
	This citation relates	to Complaint IN00419836.				
	3.1-38(a)(3)(D) 3.1-38(a)(3)(E)					
F 0684 SS=E Bldg. 00	applies to all treat facility residents. I comprehensive as facility must ensur	a fundamental principle that ment and care provided to				

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12/20/2023 PRINTED: DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED OMB NO. 0938-039 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 11/20/2023 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 professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. Based on observation, record review, and F 0684 12/04/2023 Munster Med-Inn interview, the facility failed to ensure areas of Annual Survey: 11/20/2023 bruising and scabbing were assessed and Please accept the following as the monitored and lotion was applied to dry scaly feet facility's credible allegation of for 8 of 9 residents reviewed for skin conditions compliance. This plan of non-pressure related. The facility also failed to correction does not constitute an ensure residents were monitored for constipation admission of guilt or liability by the for 1 of 1 resident reviewed for constipation. facility and is submitted only in (Residents N, E, K, C, G, M, J, and H) response to the regulatory requirement. Findings include: F684 Quality of Care What corrective action(s) will 1. On 11/15/23 at 10:26 a.m. and 3:00 p.m., be accomplished for those Resident N was observed in their room in bed. A residents found to have been fading purple bruise was observed on the top of affected by the deficient their left hand. practice; Resident's M, K, N, H, and E-On 11/16/23 at 9:26 a.m. and 11:28 a.m., the Bruises were assessed, MD was bruising remained to the resident's left hand. notified. New orders were obtained to monitor bruising. The record for Resident N was reviewed on Resident G- New orders were received to prevent future

11/16/23 at 2:23 p.m. Diagnoses included, but were not limited to, palliative care, dementia with behavior disturbance, and peripheral vascular disease (PVD).

The Quarterly Minimum Data Set (MDS) assessment, dated 8/15/23, indicated the resident was moderately impaired for daily decision making. The resident required extensive assistance for bed mobility.

There was no Care Plan related to the resident's bruise.

The Weekly Skin Observation form, dated 11/14/23, indicated the resident's skin was intact.

same deficient practice and what corrective action will be All residents have the potential to be affected by the same alleged deficient practice. What measures will be put into

Resident J'-s scabbed area was

Resident's -C dry skin was

How the facility will identify

potential to be affected by the

other residents having the

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constipation.

addressed.

addressed.

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PRINTED: 12/20/2023 FORM APPROVED

CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-039 STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING COMPLETED

	155131	B. WING		11/20/2023	
NAME OF	PROVIDED OF CURNITIES	STREET	ADDRESS, CITY, STATE, ZIP COD		
NAME OF	PROVIDER OR SUPPLIER	7935 C	CALUMET AVE		
MUNST	ER MED-INN	MUNS	TER, IN 46321		
(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 APPROPRIATION	COMPLETION	
TAG	REGULATORY OR LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)	DATE	
	There was no documentation about the resident's		place or what systemic		
	bruise.		changes will be made to		
			ensure that the deficient		
	Interview with the Assistant Director of Nursing		practice does not recur;		
	on 11/17/23 at 2:03 p.m., indicated there was no		Nurses were re-educated on:		
	additional documentation related to the resident's		Addressing and assessir	ng	
	bruising.		changes in skin condition such	as	
			bruises, obtaining orders for		
	2. On 11/14/23 at 2:13 p.m., Resident E was		treatment, and implementation	of	
	observed in their room in bed and was wearing a		treatment.		
	hospital gown. Large areas of reddish/purple		Assistive clinical staff were		
	bruising were observed to their bilateral forearms		educated on:		
	and hands. The resident was not wearing geri		Notifying the nurse of an	у	
	sleeves (protective arm coverings) at that time.		change in residents' skin		
			conditions.		
	On 11/15/23 at 2:45 p.m., the resident was		How the corrective action(s)		
	observed in their room seated in his wheelchair.		will be monitored to ensure t	he	
	The resident was dressed and geri sleeves were in		deficient practice will not		
	use.		recur, i.e., what quality		
	TI 10 D 11 (F 1 1		assurance programs will be p	out	
	The record for Resident E was reviewed on		into place;		
	11/16/23 at 9:51 a.m. Diagnoses included, but		Facility Angels/designee will		
	were not limited to, stroke, dementia with other		complete observation rounds of		
	behavior disturbance, major depressive disorder, and chronic kidney disease Stage 3. The resident		10 residents 3 times per week		
	did not have a diagnosis of purpura (a rash of		ensure areas of bruising, dry s or scabbed areas are reported		
	purple spots due to small blood vessels leaking		the nurse.	10	
	blood into the skin).		Nurse Managers will review 10	1	
	blood into the skin).		residents Point of Care (POC)		
	The Quarterly Minimum Data Set (MDS)		documentation weekly to ensu		
	assessment, dated 9/11/23, indicated the resident		residents with no bowel mover		
	was moderately impaired for daily decision		for 3 days or more are provide		
	making, required extensive assistance with bed		intervention for constipation.		
	mobility and moderate assistance with transfers.		Director of Nursing/designee v	<sub>/ill</sub>	
			present a summary of the aud		
	A Care Plan, dated 6/26/23 and reviewed on		to the Quality Assurance	·==	
	9/11/23, indicated the resident was at risk for		committee monthly for 4 month	ns.	
	complications related to anticoagulant therapy		Thereafter, if determined by th		
	use. Interventions included, but were not limited		Quality Assurance committee,		
		1	1	1	

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to, daily skin inspection per facility protocol and

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auditing and monitoring will be

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. B	JILDING	00	COMPL	ETED
		155131	B. W	ING		11/20/	2023
				STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF I	PROVIDER OR SUPPLIE	R			ALUMET AVE		
MUNSTE	R MED-INN				ER, IN 46321		
	1			<u> </u>	,		
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX		NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION	-	TAG			DATE
	report abnormalitie				done quarterly and present		
		/report as needed (PRN)			quarterly at the QA meeting.		
	adverse reactions of antiplatelet therapy: blood tinged or red blood in urine, black tarry stools,				Monitoring will be on going.		
	_				Date by which systemic		
	_	blood in stools, sudden severe			corrections will be complete	a:	
		vomiting, diarrhea, muscle , bruising, blurred vision,			12/4/2023		
		, loss of appetite, sudden					
		status, and significant or					
	sudden changes in						
	sudden changes in	vitai signs.					
	Δ Physician's Orde	er, dated 11/1/23, indicated the					
	resident was to receive Plavix (an antiplatelet						
	medication) 75 milligrams (mg) one time a day.						
	medication) /5 min	ngrams (mg) one time a day.					
	A Physician's Orde	er, dated 11/15/23, indicated the					
	1	ar geri sleeves or long sleeves					
		protection. The geri sleeves					
	could be removed f	-					
	The Weekly Skin (	Observation form, dated 11/9/23,					
	indicated the reside	ent's skin was intact and no					
	concerns were note	ed.					
	Interview with the	Assistant Director of Nursing					
		23 at 2:30 p.m., indicated the					
	resident's bruises sl	hould have been monitored.					
		10:39 a.m., Resident K was					
		oom in bed. A fading green					
	bruise was observe	d on the left hand.					
	0 11/17/00 : 0 1	4 4 6 1					
		4 a.m., the fading green bruise					
	remained to Reside	ent K's left hand.					
	The record for Pos	ident K was reviewed on					
	11/17/23 at 9:49 a.m. Diagnoses included, but were not limited to, muscle weakness, malaise,						
		cer, bed confinement, and					
		The resident was admitted to					
	reduced illoulity.	THE TESTUCIII WAS AUTHILIEU IO	1				l

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155131		JILDING	instruction 00	(X3) DATE COMPL 11/20/	ETED	
	PROVIDER OR SUPPLIEF	<b>.</b>	7935 C	ADDRESS, CITY, STATE, ZIP COD ALUMET AVE ER, IN 46321		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
		nimum Data Set (MDS)				
		orogress.  rsing assessment, dated entify the bruising to the left				
		r, dated 11/10/23, indicated the to be assessed weekly on vevening.				
	(MAR), indicated the signed out as being	the skin assessments were completed on 11/10 and as no documentation indicating bruises.				
	on 11/17/23 at 3:05	Assistant Director of Nursing p.m., indicated the area of lent's left hand was not ored.				
	observed in their ro were exposed and e resident was observ soles of both feet at with the resident at	11:23 a.m., Resident C was om in bed. The resident's feet elevated on a blanket. The red with dry, scaly skin to the and along the arch. Interview that time, indicated on d put lotion on their feet and				
		30 a.m., the resident was again scaly skin to her feet.				
		8 a.m., 11:30 a.m., and 1:54 p.m., emained dry and scaly.				
	The record for Resi	dent C was reviewed on				

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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 11/20/2023	
	ROVIDER OR SUPPLIER		7935 C	ADDRESS, CITY, STATE, ZIP COD ALUMET AVE FER, IN 46321	
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OF	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 BE CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	
	11/16/23 at 11:03 a.m. Diagnoses included, but were not limited to, hemiplegia and hemiparesis (muscle weakness and paralysis) following a stroke, type 2 diabetes, and epilepsy.				
	assessment, dated 8	mum Data Set (MDS) /16/23, indicated the resident act and required extensive sonal hygiene.			
	The resident had no to their feet.	current order to apply lotion			
	The Weekly Skin Observation form, dated 11/15/23, indicated the resident's skin was intact. There was no documentation related to the resident's scaly feet.				
	(ADON) on 11/20/2 should have been ap On 11/14/23 1:52 p and 3:15 p.m., on 1 p.m., and on 11/17/ Resident G was obs	Assistant Director of Nursing 23 at 1:00 p.m., indicated lotion opplied to the resident's feet. 5m., on 11/15/23 at 10:48 a.m. 1/16/23 at 9:15 a.m. and 1:50 23 at 8:04 a.m. and 9:33 a.m., served in bed. At those times g thick toenails with dry scaly			
	11/15/23 at 3:32 p.1 not limited to, mult dementia, major de disorder, paraplegia	dent G was reviewed on m. Diagnoses included, but were iple sclerosis, vascular pressive disorder, mood n, hammer toes for left and right rmity, pain in the toes, fecal tion, and anxiety.			
	assessment, indicate impaired for decision	rly Minimum Data Set (MDS) ed the resident was severely on making and had short and problems. The resident needed			

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STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MUI	LTIPLE CO	NSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUII	LDING	00	COMPL	ETED
		155131	B. WIN	G		11/20/	2023
			<u> </u>	STREET A	DDRESS, CITY, STATE, ZIP COD		
NAME OF F	PROVIDER OR SUPPLIEF	₹		7935 CA	ALUMET AVE		
MUNSTE	R MED-INN			MUNST	ER, IN 46321		
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	ICY MUST BE PRECEDED BY FULL	P	REFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE	COMPLETION
TAG		h 2 person physical assist for	+	TAG	BEIGERETI		DATE
		ileting, and an extensive assist					
		vsical assist for personal					
		nd eating. The resident was					
		ent of bowel and was not on a					
	bowel toileting prog	gram.					
		d on 6/30/23, indicated the					
	resident had impaired skin integrity to the right outer ankle. The approaches were to render treatment as per orders.  A Care Plan, initiated on 9/1/23, indicated the resident was at risk for constipation related to						
		proaches were to implement the					
	_	b bowel movement every 3					
	days.						
	There were no Phys	sician's Orders for any type of					
		ent's dry scaly skin on their					
	feet.	not any sound summer					
		ted 8/27/23 at 1:26 a.m.,					
		.m., the resident was observed					
	_	ir name was called but they did					
		The resident's blood pressure rature was 101.2, and the pulse					
		ician was notified and new					
	1	esident to the emergency room					
		resident left the facility at 1:20					
	a.m.	-					
	m						
	1	ysical from the hospital, dated					
	· ·	he assessment of the resident gallstones) with possible					
		flamed gallbladder), abdominal					
		e constipation with massive					
	fecal impaction of s	-					
	A Cat Scan (CT) of	the pelvis without contrast,					

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STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MU	LTIPLE CO	NSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUI	LDING	00	COMPL	LETED
		155131	B. WIN	lG		11/20	/2023
			—	CTDFFT .	DDDECC CITY CTATE TIP COP		
NAME OF P	PROVIDER OR SUPPLIEF	3			ADDRESS, CITY, STATE, ZIP COD		
MUNICEE					ALUMET AVE		
MONSTE	R MED-INN			MONSI	ER, 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 APPROPRIATE		TE	COMPLETION	
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	dated 8/27/23, indic	cated high grade constipation					
	with massive fecal	impaction of the sigmoid colon					
	in the rectum.						
	The resident returns	ed to the facility on 8/31/23.					
	Physician's Orders	dated 6/9/23, indicated					
		0 milligrams/5 milliliters (ml),					
	give 5 ml two times						
	powder 17 grams every morning for constipation						
	and Lactulose 10 grams/15 ml, give 30 ml at						
	bedtime for constipation.						
	Physician's Orders, dated 8/31/23, indicated						
	Senokot S oral table	et 8.6-50 milligrams (mg) (a					
	stimulant laxative),	give 2 tablets via the peg tube					
	every 24 hours as n	eeded for constipation.					
	The Devict Meyers	ant (DM) Decemble disected the					
		ent (BM) Record indicated the l BM on 8/22, 2 small BM's on					
		24 and 8/25 and 1 small BM on					
	8/26/23.	4 and 8/23 and 1 small blvi on					
	6/20/23.						
	The BM Record inc	dicated the resident had no BM					
	on 9/8, 9/9, and 9/1	10/23. There was no BM					
	recorded on 10/5, 1	0/6, 10/7, 10/29, 10/30, 10/31,					
	and 11/1/23.						
		ministration Record (MAR) for					
		23,10/2023 and 11/1-11/16/23,					
		eation of Senokot S oral tablet					
		d for constipation had not been					
	administered.						
	Interview with the S	Second Floor Unit Manager					
		at 8:45 a.m., indicated the					
	` ′	history of constipation and					
		ing should be done if there					
		ement. She was unaware the					
	was no bower move						

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	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155131			(X3) DATE SURVEY COMPLETED 11/20/2023		
	PROVIDER OR SUPPLIEI	R	793	35 CA	DDRESS, CITY, STATE, ZIP COD ALUMET AVE ER, IN 46321		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
TAG	Interview with the indicated she put in Lactulose for the redays of no bowel numedication should.  The current 9/20/2 policy, provided by Nursing on 11/17/2 residents who had considered for phannon-pharmacologic juice, or encourage taken into consider have a "normal" be hours without considered on an analysis of the part of the	UM on 11/17/23 at 3:20 p.m., an an order for an extra dose of esident. She indicated after 3 movement, the "as needed" have been used.  1, "Bowel Elimination Protocol" the Assistant Director of 23 at 3:23 p.m., indicated no BM for 72 hours will be remacological intervention or eal intervention, such as prune increased fluids. It should be ration that some residents may owel pattern of greater than 72 tipation. Each resident should in individual basis.	TAG	3	DEFICIENCY)		DATE
	6. During an interview with Resident M on 11/14/23 at 11:47 a.m., the resident indicated there was a bruise to their right outer hand. At that time, they removed the geri sleeve and the red/purple bruised area was observed.						
	11/16/23 at 11:03 a were not limited to pulmonary disease	-					
	assessment, indicat cognitively intact.	erly Minimum Data Set (MDS) ted the resident was The resident received oxygen the last 7 days and an cation.					
	The Care Plan, rev	ised on 6/13/23, indicated the					

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	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE C A. BUILDING	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED
AND PLAN	OF CORRECTION	155131	A. BUILDING B. WING	00	11/20/2023
	PROVIDER OR SUPPLIEF		7935 C	ADDRESS, CITY, STATE, ZIP COD CALUMET AVE TER, IN 46321	1
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX TAG	1	CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	COMPLETION DATE
TAG	resident had potenti integrity related to the anticoagulant medic document weekly side of the properties of the properti	al/ actual impairment to skin the use and side effects of the cation. The approaches were to kin observations.  dated 5/10/23, indicated gerives to be worn at all times for dated 5/20/23, indicated gulant medication) 2.5 to times a day.  n observation was dated m. and there were no bruises or erns indicated.  mentation in Nurses' Notes 3 regarding any bruising to their second Floor Unit Manager at 8:45 a.m., indicated she was at had a bruise to the right  UM on 11/17/23 at 3:20 p.m., was new and she asked the ot it and the resident indicated g the side rail while in bed.  0:45 a.m., Resident J was in a wheelchair by the Nurses'	TAG	DEFICIENCY	
	areas on the residen above the left eye a side of the cheek.  The record for Resi	e, there were 2 large scabbed it's face. One scab was located and the other was on the right dent J was reviewed on			
	I 11/16/23 at 3:03 p.r	n Diagnoses included, but	I	1	ı

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CENTERS FOI	R MEDICARE & MEDIC	CAID SERVICES				OM	IB NO. 0938-039
STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPI	LETED
		155131	B. W	ING		11/20	/2023
				STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF I	PROVIDER OR SUPPLIE	I.R			ALUMET AVE		
MUNSTE	ER MED-INN				ER, IN 46321		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIE)	NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPR		COMPLETION
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	were not limited to	o, stroke, Alzheimer's disease,					
	pressure ulcer of the	ne sacral region, psychotic					
	disorder, major dej	pressive disorder, and					
	osteoarthritis.						
	The 10/22/23 Mod	lification of the Quarterly					
	Minimum Data Se	t (MDS) assessment, indicated					
	the resident was rarely understood/understands						
	and was severely in	mpaired for decision making.					
	The resident had 1	stage 3 pressure ulcer.					
	A Care Plan, revised on 11/15/23, indicated the						
	resident was at risk	c for complications related to					
	impaired skin integ	grity. The approaches were to					
	evaluate the skin a	nd skin integrity.					
	The last Weekly S	kin Assessment, completed on					
		d there was no skin breakdown.					
		mentation regarding the					
		he right cheek and above the					
	left eye.	Ç					
	There was no docu	mentation in Nursing Progress					
		23 through 11/16/23 regarding					
	the scabbed areas t						
	ine seassed areas t	to the face.					
	Interview with the	Second Floor Unit Manager					
		at 8:40 a.m., indicated she had					
		ed areas were from their					
		here was no documentation in					
	the record to reflec						
	ale record to reflec	ot mat.					
	Interview with the	Second Floor UM on 11/17/23					
		ated there was no documentation					
	_	ompleted of the scabbed areas					
		ce. The UN indicated they have					
		ong, however, nothing was					
		11/14/23 at 10:25 a.m., a					
	1 accumented of Oll	11/11/40 at 10.40 a.H., a					

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reddish/ burgundy discoloration was observed on

Resident H's bilateral forearms.

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STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MU	JLTIPLE CO	NSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	ILDING	00	COMPL	ETED
		155131	B. WI	NG		11/20/	/2023
				CTDFFT A	DDDFGG CITY CTATE ZID COD		
NAME OF P	ROVIDER OR SUPPLIEF	₹			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	EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPR		(EACH CORRECTIVE ACTION SHOULD BE	TE	COMPLETION	
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	The record for Resi 11/16/23 at 9:30 a.r were not limited to, disease, hypertension	25 a.m., the fading discoloration ident's bilateral forearms.  dent H was reviewed on m. Diagnoses included, but chronic obstructive pulmonary on, and type 2 diabetes.					
	assessment, dated 8/26/23, indicated the resident had cognitive impairment. The resident needed extensive assistance with bed mobility and						
	transfers.						
	The Weekly Skin Observation sheet, dated 11/14/23, indicated the resident's skin was intact and there was no documentation of bruising.  Interview with the Assistant Director of Nursing (ADON) on 11/20/23 at 2:53 p.m., indicated she reported the resident's bilateral forearm bruising to the nurse and there was now an order for the bruising to be monitored.						
	A policy titled "Ski	n Condition Assessment &					
	Monitoring Pressur	e and Non-Pressure" received					
		Assistant Director of Nursing					
		23 at 3:23 p.m., indicated:					
	"Non- pressure sk						
	· ·	, abrasions, lacerations,					
		urgical wounds, etc.) Will be					
	assessed for healing progress and signs of						
	complications or in	tection weekly"					
	This citation relates and IN00420643.	s to Complaints IN00418486					
	3.1-37(a)						
			1				

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STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTI	IPLE CON	NSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDI	ING	00	COMPL	LETED
		155131	B. WING			11/20	/2023
			ет	TREET AT	DDRESS, CITY, STATE, ZIP COD		
NAME OF P	PROVIDER OR SUPPLIER	t .			LUMET AVE		
MUNSTF	R MED-INN				ER, IN 46321		
	T						1
(X4) ID		STATEMENT OF DEFICIENCIE	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX		CY MUST BE PRECEDED BY FULL	PREI		(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION	TA	AG	DEFICIENCY)		DATE
F 0685	483.25(a)(1)(2)						
SS=D		s to Maintain Hearing/Vision					
Bldg. 00	§483.25(a) Vision	_					
		sidents receive proper					
	treatment and assistive devices to maintain vision and hearing abilities, the facility must, if necessary, assist the resident-  §483.25(a)(1) In making appointments, and  §483.25(a)(2) By arranging for transportation to and from the office of a practitioner						
		treatment of vision or					
		nt or the office of a					
		ializing in the provision of					
	vision or hearing a	•					
		view and interview, the facility	F 0685		Munster Med INN		12/04/2023
		Optometrist's recommendation			Annual Survey: 11/20/2023		
	for eye drops was c	ompleted in a timely manner			-		
	for 1 of 4 residents	reviewed for communication			Please accept the following as	the	
	and sensory. (Resid	ent 146)			facility's credible allegation of		
					compliance. This plan of		
	Finding includes:				correction does not constitute	an	
					admission of guilt or liability by	/ the	
	_	on 11/14/23 at 2:49 p.m.,			facility and is submitted only in	1	
		ited she had seen the eye			response to the regulatory		
		new glasses were ordered, but			requirement.		
	she had not received	d them.			F685 Treatment /Devices to		
					Maintain Hearing/Vision	_	
		dent 146 was reviewed on			What corrective action(s) wil	I	
	_	m. Diagnoses included, but were			be accomplished for those		
		rtensive chronic kidney			residents found to have beer	1	
		etes, end stage renal disease,			affected by the deficient		
		al dialysis, acute kidney failure,			practice;		
	repeated falls, and e	систа.			Orders were received from the	;	
	The 0/6/22 Onorton	ly Minimum Data Set (MDS)			physician for eye drops for		
	assessment, indicate				resident 146.		
		The resident's vision was			How the facility will identify other residents having the		
	1 -	ective lens. She had no oral			potential to be affected by th	•	
1	adequate with colle	enve iciis. Blic had liu ulai	I		potential to be affected by th	<del>-</del>	1

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12/20/2023 PRINTED:

	T OF HEALTH AND HU! R MEDICARE & MEDIC				FORM APPROVED OMB NO. 0938-039	
STATEME	NT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155131	(X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING		(X3) DATE SURVEY  COMPLETED  11/20/2023	
NAME OF	PROVIDER OR SUPPLIER	₹		ADDRESS, CITY, STATE, ZIP COD		
MUNSTE	ER MED-INN			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	COMPLETION	
TAG		R LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)	DATE	
		122 pounds, and has had a		same deficient practice and		
		oss. The resident received		what corrective action will b	е	
	dialysis as a resider	nt.		taken;		
				All facility residents requiring		
		gress Note, dated 4/13/23,		vision services have the poter		
		nt had mild dry eyes for both		to be affected by the same all	leged	
		a new medication order of		deficient practice.		
	_	almology Solution apply 1		What measures will be put in	nto	
	drop into both eyes twice a day for indefinitely.  The order was written and given to Social Service.  At that time, new glasses were not recommended.			place or what systemic		
				changes will be made to		
				ensure that the deficient		
			practice does not recur;			
	An Optometry Progress Note, dated 5/24/23,			Staff were educated on ensur	ring	
		nt now had moderate dry eyes		optometry		
	-	patient states she never		recommendations/follow up is	3	
		from the last visit." A new		completed timely.		
		or Refresh Plus Ophthalmology		How the corrective action(s)		
		op into both eyes twice a day		will be monitored to ensure	the	
	-	written and given to and		deficient practice will not		
	discussed with Soci	ial Service.		recur, i.e., what quality		
				assurance programs will be	put	
		dated 5/24/23, indicated Eye		into place;		
	_	elief Ophthalmic Solution		Social Service/designee will a		
	1	till 1 drop in both eyes two		weekly to see if any residents		
	times a day for dry	eyes.		were seen by optometry, if so		
				Unit Manager/designee will er		
		Second Floor Unit Manager on		recommendations are followe		
	_	m., indicated the resident saw		Director of Nursing /designee	· · · · · · · · · · · · · · · · · · ·	
	1	2023 and he did recommend		present a summary of the aud	dits	
		For dry eyes. He wrote the		to the Quality Assurance		
		n's Order form, however,		committee monthly for 4 mon		
	_	he order because it was given		Thereafter, if determined by the	· · · · · · · · · · · · · · · · · · ·	
	to Social Service.			Quality Assurance committee		
				auditing and monitoring will be	e	
	3.1-39(a)(1)			done quarterly and present		
				quarterly at the QA meeting.		
				Monitoring will be on going.		

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Date by which systemic corrections will be completed:

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OBIGIERO I OI	THE CONTENTS OF THE PARTY	IIID GEITT TOES			312 1.31 0700 007
STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE C	ONSTRUCTION	(X3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING	00	COMPLETED
		155131	B. WING		11/20/2023
			<del></del>	_	
NAME OF F	PROVIDER OR SUPPLIEF	₹		ADDRESS, CITY, STATE, ZIP COD	
	D MED INT			CALUMET AVE	
MUNSTE	R MED-INN		MUNS	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 APPROPRIAT	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)	DATE
				12/4/2023	
F 0686	483.25(b)(1)(i)(ii)				
SS=D	Treatment/Svcs to Prevent/Heal Pressure				
Bldg. 00	Ulcer				
-	§483.25(b) Skin Ir	ntegrity			
	§483.25(b)(1) Pre				
	. , , , ,	prehensive assessment of			
		ility must ensure that-			
	l '	ives care, consistent with			
	l ' '	dards of practice, to prevent			
	_ ·	nd does not develop			
	pressure ulcers unless the individual's clinical				
	condition demonstrates that they were				
	unavoidable; and				
		pressure ulcers receives			
	1 ' '	ent and services, consistent			
	1	standards of practice, to			
	1	prevent infection and prevent			
	new ulcers from d	· · · · · · · · · · · · · · · · · · ·			
		on, record review, and	F 0686	Munster Med-Inn	12/04/2023
		ty failed to ensure pressure	1 0000	Annual Survey: 11/20/2023	12/07/2023
		d securely with a bandage as		Please accept the following as	the
		sician and treatment orders		facility's credible allegation of	== = = = = = = = = = = = = = = = = = =
		ly for new pressure sores for 2		compliance. This plan of	
		wed for pressure ulcers.		correction does not constitute	an
	(Residents G and J)	-		admission of guilt or liability by	
	(_testasino G und 0)			facility and is submitted only in	
	Findings include:			response to the regulatory	
	- mamas morado.			requirement.	
	1. On 11/14/23 at 1	1:52 p.m., Resident G was		F686 Treatment/Svcs to	
		that time, their feet were		Prevent/Heal Pressure	
		ectly on the mattress and not		Ulcers	
	, , ,	ided. The top right foot was		What corrective action(s) will	
	_	dy scabs and the foot was		be accomplished for those	
		as no dressing observed.		residents found to have been	
	originated. There w	as no areasing coserved.		affected by the deficient	
	On 11/15/23 at 10-/	48 a.m., and 3:15 p.m., and		practice;	
	On 11/13/23 at 10.5	to a.m., and 5.15 p.m., and	ı	practice,	1

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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 11/20/2023 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 11/16/23 at 9:15 a.m., 1:50 p.m., the resident was Resident J's- treatment was observed in bed. At those times, their feet were immediately replaced. observed laying directly on the mattress and not Resident G's feet were suspended or offloaded. The top right foot was immediately off-loaded. Resident observed with bloody scabs and the foot was G's MD was notified, and orders bright red. were obtained for newly identified pressure ulcer. On 11/17/23 at 8:04 a.m., the resident was How the facility will identify observed in bed and their feet were laying directly other residents having the on the mattress and not suspended or offloaded. potential to be affected by the There was a white bandage observed to the right same deficient practice and foot dated 11/16/23. what corrective action will be taken: During a wound treatment observation on All residents with pressure ulcers 11/17/23 at 9:33 a.m., the wound care nurse was have the potential to be affected observed completing the treatment for the right by the same alleged deficient foot. She removed the old bandage from the right practice. foot. The area was bright red with multiple What measures will be put into scabbed areas, and 2 dark purple sores were place or what systemic observed under the right foot. One area was hard changes will be made to with a black scab and the other area was open. ensure that the deficient practice does not recur: The record for Resident G was reviewed on Nurses were re-educated on the 11/15/23 at 3:32 p.m. Diagnoses included, but were following: not limited to, multiple sclerosis, vascular Ensuring ordered dementia, major depressive disorder, mood preventative measure are in place disorder, paraplegia, hammer toes for left and right for at risk residents feet, right foot deformity, pain in the toes, fecal Obtaining orders and impaction, constipation, and anxiety. implementing timely treatment for new skin conditions. The 9/14/23 Quarterly Minimum Data Set (MDS) Notifying MD and resident assessment, indicated the resident was severely responsible party of new skin impaired for decision making and had short and conditions. long term memory problems. The resident needed Replacing treatment extensive assist with 2 person physical assist for dressings that are soiled or bed mobility and toileting, and an extensive assist detached from wound timely. with a 1 person physical assist for personal Assistive staff were re-educated hygiene, dressing and eating. The resident was frequently incontinent of bowel and was not on a Notifying the nurse

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bowel toileting program.

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immediately when a treatment has

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STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CC	ONSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	ЛLDING	00	COMPL	ETED
		155131	B. W	ING		11/20/	2023
				STREET A	ADDRESS, CITY, STATE, ZIP COD	<u> </u>	
NAME OF P	PROVIDER OR SUPPLIEF	8			ALUMET AVE		
MUNSTE	R MED-INN				ER, IN 46321		
		OTATEMENT OF PERIODS	1		· [		375)
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
PREFIX	,	ICY MUST BE PRECEDED BY FULL		PREFIX	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	become soiled or detached fro		DATE
	A Care Plan revise	d on 6/30/23, indicated the			wound.	MII	
		ed skin integrity to the right			How the corrective action(s)		
	_	proaches were to render			will be monitored to ensure t	ho	
	treatment as per ord	-			deficient practice will not	116	
	treatment as per ore	icis.			recur, i.e., what quality		
	A weekly skin obse	ervation, dated 11/14/23 at 12:12			assurance programs will be	put	
	•	elesions on the left and right			into place;	Pat	
	•	ew. Wound care was being			Wound nurse/designee will		
	provided.	5			randomly audit 10 residents		
	•				identified to be at risk for skin		
	A Wound Observation Assessment, dated				breakdown or with existing ski	n	
	11/16/23, indicated the right lateral foot was				breakdown to ensure skin		
	observed with a deep tissue injury that measured				conditions are documented an	ıd	
	5 centimeters (cm) by 8 cm. There was 75% of				orders obtained, and treatments		
	epithelial (pale pink	or red tissue.		are in place per orders.			
					Director of Nursing/designee v	vill	
	An old deep tissue	injury to the right lateral foot			present a summary of the aud	its	
	was resolved on 8/3	3/23.			to the Quality Assurance		
					committee monthly for 4 mont	hs.	
	-	dated 5/24/23, indicated to			Thereafter, if determined by th	ie	
	suspend or offload	heels while in bed.			Quality Assurance committee,		
					auditing and monitoring will be	;	
	-	dated 11/16/23, indicated			done quarterly and present		
	_	foot with wound cleanser or			quarterly at the QA meeting.		
		y an Adaptic bandage, and			Monitoring will be on going.		
		sing every day shift on			Date by which systemic		
		ay, and Friday. May see the			corrections will be complete	d:	
	wound doctor.				12/4/2023		
	Intomviore!41-41 (	Sacand Elaga Unit Manager					
		Second Floor Unit Manager on					
	should be offloaded	m., indicated the resident's heels					
	should be officaded	i willie III dea.					
	Interview with the	Wound Nurse on 11/17/23 at					
	9:40 a.m., indicated while she was changing the resident's roommate's bandage yesterday and						
		octor had left, the CNA					
		indicated she needed to look					
		at foot. The Wound Nurse					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING 00 B. WING			(X3) DATE SURVEY COMPLETED 11/20/2023			
	PROVIDER OR SUPPLIER	2	7935 C	ADDRESS, CITY, STATE, ZIP COD ALUMET 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 COMP	X5) LETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION	TAG	CROSS-REFERENCED TO THE APPRO DEFICIENCY)		TE
TAG	indicated this was to aware the resident's The Wound Doctor assess the wound, he foot before. The Wound and treat new the resident's heels offloaded while in borders.  2. On 11/17/23 at 9 observed in bed. The	he first time she was made right foot had open areas. had just left and did not nowever, he had treated this bound Doctor will assess the at week during his rounds. It is should be suspended or bed. There were no further the start, Resident J was are resident was just put back	TAG	DETCHACTI	DA	TE.
	observed in bed. The resident was just put back to bed at 8:30 a.m. At that time, the Wound Nurse was going to change the resident's bandage to the pressure ulcer on her coccyx. The Wound Nurse removed the resident's incontinent brief which was soaked with urine and there was no bandage covering the pressure ulcer. The pressure ulcer was red in color with white edges.					
	11/16/23 at 3:03 p.1 were not limited to, pressure ulcer of the	dent J was reviewed on m Diagnoses included, but stroke, Alzheimer's disease, e sacral region, psychotic ressive disorder, and				
	Minimum Data Set the resident was rar and was severely in	fication of the Quarterly (MDS) assessment, indicated ely understood/understands in paired for decision making. stage 3 pressure ulcer.				
	resident had a press The approaches we ordered and monito monitor dressing to	sed on 6/20/23, indicated the sure ulcer to the sacral area. The to administer treatments as a for effectiveness, and the ensure it was intact and the ose dressings to the treatment				

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STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		NSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDI	NG	00	COMPLETED	
		155131	B. WING			11/20/	2023
<u> </u>			STF	REET A	DDRESS, CITY, STATE, ZIP COD		
NAME OF P	ROVIDER OR SUPPLIER		79	35 CA	ALUMET AVE		
MUNSTER MED-INN			MU	UNSTI	ER, IN 46321		
(X4) ID	SUMMARY 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 APPROPRIATE OF THE APPROPRIATE	E	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION	TAG	.G	DEFICIENCY)		DATE
	Dhygigian's Ordara	dated 11/16/23, indicated					
		n normal saline, apply collagen,					
		n dressing every day shift on					
		y, and Friday and as needed.					
	wionday, wednesda	y, and Triday and as needed.					
	The last documented	d Wound Measurement was					
		Stage 3 pressure ulcer					
		neters (cm) by 1.4 cm by 1.0 cm.					
		slough (necrotic tissue) 40%					
	granulation tissue a	nd 30% other viable tissues)					
	The wound progress	s was exacerbated due to the					
	patient being non-compliant with wound care and						
	resisting offloading efforts.						
		ed 11/17/23 at 6:54 a.m.,					
		nt was gotten up out of bed					
	_	eir request. The resident was					
	sitting up in the who	eelchair by nurses station.					
	Interview with the V	Wound Nurse on 11/17/23 at					
		she was unaware the pressure					
	ulcer had no bandag	-					
	uno in a annua g	, 0 0 0 1 100					
	The current and 9/1	/20 "Skin Condition					
	Assessment and Mo	onitoring Pressure and Non					
		ovided by the Assistant					
	Director of Nursing	on 11/17/23 at 3:23 p.m.,					
		lcers will be assessed and					
	measured at least w	eekly by the licensed nurse					
		the resident's clinical record.					
	Dressings which were applied to pressure ulcers,						
	·	nds shall include the date of					
	the licensed nurse w	who performed the procedure.					
	This citation relates	to Complaint IN00420643.					
	3.1-40(a)(2)						
			I	l			

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CENTERS FOR	R MEDICARE & MEDIC	CAID SERVICES				OM	IB NO. 0938-039
STATEMEN	NT 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	LETED
		155131	B. W	ING		11/20	/2023
			<b>_</b>	STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF PROVIDER OR SUPPLIER				7935 C	ALUMET AVE		
MUNSTER MED-INN			MUNST	ΓER, 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 APPROPRIATE	ΓΕ	COMPLETION
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
F 0687	483.25(b)(2)(i)(ii)						
SS=D	Foot Care						
Bldg. 00	§483.25(b)(2) Foo	ot care.					
		sidents receive proper					
	treatment and car	re to maintain mobility and					
	good foot health,	the facility must:					
	(i) Provide foot ca	are and treatment, in					
	accordance with professional standards of						
	practice, incl	, including to prevent					
	complications from	m the resident's medical					
	condition(s) and (ii) If necessary, assist the resident in making appointments with a qualified person, and						
	arranging for tran	sportation to and from such					
	appointments.						
		on, record review, and	F 00	587	Munster Med INN		12/04/2023
	interview, the facil	ity failed to ensure dependent			Annual Survey: 11/20/2023		
		foot care and had routine visits					
	_	lated to long and thick toenails			Please accept the following as	the	
	for 1 of 11 resident	s reviewed for ADL's. (Resident			facility's credible allegation of		
	G)				compliance. This plan of		
		Finding includes:			correction does not constitute		
	Finding includes:				admission of guilt or liability by		
					facility and is submitted only in	ı	
	On 11/14/23 1:52 p.m., on 11/15/23 at 10:48 a.m.				response to the regulatory		
		1/16/23 at 9:15 a.m. and 1:50			requirement.		
		/23 at 8:04 a.m. and 9:33 a.m.,			F687 Foot Care		
		served in bed. At those times			What corrective action(s) will	Í	
		ng thick toenails with dry scaly			be accomplished for those		
	skin on both feet.				residents found to have been	ı	
	m				affected by the deficient		
		ident G was reviewed on			practice;		
	_	m. Diagnoses included, but were			Resident G was added to the		
		tiple sclerosis, vascular			facilities next podiatry visit list.		
		epressive disorder, mood			How the facility will identify		
		a, hammer toes for left and right			other residents having the		
	_	ormity, pain in the toes, fecal			potential to be affected by the	е	
	impaction, constipa	ation, and anxiety.			same deficient practice and		1

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The 9/14/23 Quarterly Minimum Data Set (MDS)

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taken;

what corrective action will be

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(VA) MITTER E ~	ONIGER LIGHTON	OVA) DATE CHRAZEV		
		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CO		(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING	00	COMPLETED	
		155131	B. WING		11/20/2023	
NAME OF E	PROVIDER OR SUPPLIER		STREET A	ADDRESS, CITY, STATE, ZIP COD	-	
WHILE OF TROVIDER OR BUILDIER				ALUMET AVE		
MUNSTER MED-INN			MUNS	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	COMPLETION	
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)	DATE	
	assessment, indicate	ed the resident was severely		All facility residents requiring		
	impaired for decision	on making and had short and		podiatry services have the		
		problems. The resident needed		potential to be affected by the		
	extensive assist wit	h 2 person physical assist for		same alleged deficient praction	e.	
	bed mobility and to	ileting, and an extensive assist		What measures will be put in	nto	
	with a 1 person phy	vsical assist for personal		place or what systemic		
		nd eating. The resident was		changes will be made to		
		ent of bowel and was not on a		ensure that the deficient		
	bowel toileting prog	gram.		practice does not recur;		
				Staff were educated to notify	the	
	A Podiatry Exam n	ote, dated 6/21/23, indicated the		nurse and/or social service of	any	
	resident's toenails v	vere reduced in length and		resident in need of foot care s	ю .	
	thickness to 3 mm (	(millimeters). The next exam was		that they may be added to the	:	
	to be as medically r	necessary but no sooner than		podiatry list.		
	60 days.			How the corrective action(s)		
				will be monitored to ensure	the	
	Interview with the	Assistant Director of Nursing		deficient practice will not		
	on 11/17/23 at 3:20	p.m., indicated the resident		recur, i.e., what quality		
	must have been in t	the hospital when the		assurance programs will be	put	
	podiatrist was here	last, as she was on the 60 day		into place;		
	recall list to be seen	n on 11/21/23.		Social Service/designee will a	udit	
				weekly to ensure new admiss	ions	
	Interview with the	Second Floor Unit Manager on		are offered podiatry services	and	
	11/20/23 at 9:00 a.r	m., indicated they trimmed the		any resident with need for foo	t	
	resident's toenails v	vith a pair of large clippers.		care is added to the podiatry	/isit	
				list.		
	This citation relates	s to Complaint IN00418486.		Administrator /designee will		
				present a summary of the aud	lits	
	3.1-47(a)(7)			to the Quality Assurance		
				committee monthly for 4 mon	hs.	
				Thereafter, if determined by the	ne	
				Quality Assurance committee	,	
				auditing and monitoring will be	e	
				done quarterly and present		
				quarterly at the QA meeting.		
				Monitoring will be on going.		
				Date by which avetowis		
				Date by which systemic	۵.	
				corrections will be complete	u:	

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

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155131		ľ	ILDING	nstruction <u>00</u>	(X3) DATE SURVEY COMPLETED 11/20/2023		
	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		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	ATE	(X5) COMPLETION DATE
F 0690 SS=D Bldg. 00	§483.25(e) (1) The resident who is composed on admissional assistance to main or her clinical contract continence is §483.25(e)(2) For incontinence, bas comprehensive as ensure that- (i) A resident who an indwelling catholic unless the resident demonstrates that necessary; (ii) A resident who indwelling catholic catholic is assessed for as soon as possible clinical condition of catholic action is (iii) A resident who receives appropriate to prevent urinary restore continences §483.25(e)(3) For	e facility must ensure that ontinent of bladder and on receives services and ntain continence unless his dition is or becomes such not possible to maintain.  a resident with urinary ed on the resident's essessment, the facility must enters the facility without neter is not catheterized nt's clinical condition to catheterization was one enters the facility with an error subsequently receives or removal of the catheter ole unless the resident's demonstrates that					
	ensure that a resi bowel receives ap	ssessment, the facility must dent who is incontinent of propriate treatment and e as much normal bowel					

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STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPLI	ETED
15513		155131	B. WI	NG		11/20/2	2023
				STREET	ADDRESS, CITY, STATE, ZIP COD	1	
NAME OF F	PROVIDER OR SUPPLIE	R			ALUMET AVE		
MUNSTE	R MED-INN				TER, IN 46321		
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	NCY MUST BE PRECEDED BY FULL		PREFIX	CROSS-REFERENCED TO THE APPROPRI		COMPLETION
TAG		R LSC IDENTIFYING INFORMATION	-	TAG	DEFICIENCY)		DATE
	function as possil						10/04/2022
		on, record review, and	F 06	590	Munster Med-Inn		12/04/2023
		ity failed to ensure a suprapubic			Annual Survey: 11/20/2023		
		neter bag not on the floor and					
		ompleted as ordered by the			Please accept the following a		
		1 residents reviewed for			facility's credible allegation of	•	
	catheters. (Residen	t 12)			compliance. This plan of		
					correction does not constitute		
	Finding includes:				admission of guilt or liability b	-	
					facility and is submitted only i	n	
		09 a.m. and 2:47 p.m., and on			response to the regulatory		
		m. and 10:15 a.m., Resident 12			requirement.		
	was observed in bed. At those times, the foley				F690 Bowel/Bladder		
	catheter was hanging on the side of the bed,				Incontinence, Catheter, UTI		
	however, the bag w	vas touching the floor.			What corrective action(s) wi	II	
					be accomplished for those		
		30 a.m., the resident was			residents found to have bee	n	
		NA 1 was asked to remove his			affected by the deficient		
	brief to observe the	e stoma site of the supra pubic			practice;		
	catheter. The area	around the catheter was dark			Resident 12's catheter was		
	brown and crusted	over. The catheter bag was			positioned off the floor and		
	observed resting or	n the floor.			catheter care was rendered		
					immediately.		
	On 11/17/23 at 7:4	5 a.m. and 8:26 a.m., the resident			How the facility will identify		
	was observed in be	ed. At that time, the foley			other residents having the		
	catheter bag was ol	bserved on floor.			potential to be affected by the	ne	
					same deficient practice and		
	On 11/17/23 at 8:4	3 a.m., RN was asked to observe			what corrective action will b	e	
	the resident's supra	pubic ostomy site. The RN			taken;		
	removed the brief a	and the same brown crusty			All residents with indwelling		
	tissue was observe	d around the stoma.			catheters have the potential to	o be	
					affected by the same alleged		
	Interview with RN	1 at that time, indicated it was			deficient practice.		
	the nurses' responsibility to provide catheter care				What measures will be put in	nto	
	for his suprapubic	catheter.			place or what systemic		
					changes will be made to		
	The record for Res	ident 12 was reviewed on			ensure that the deficient		
	11/16/23 at 9:37 a.	m. The resident was admitted to			practice does not recur;		
	the facility on 7/26	/23 from the hospital.			Staff were re-educated on:		
	_	d, but were not limited to, type			Ensuring catheter care		

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STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	A. BUILDING <u>00</u>		COMPLETED	
15		155131	B. WING			11/20/2023	
		l .	1	CTDEET A	ADDRESS, CITY, STATE, ZIP COD	<u> </u>	
NAME OF P	ROVIDER OR SUPPLIER	8					
MUNICTE	D MED INN				ALUMET AVE		
INION21E	R MED-INN			MON21	ER, 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		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	· · · · · · · · · · · · · · · · · · ·	on's disease, stroke, dementia			orders are in place and cathet	er	
		al disturbance, urinary tract			care is rendered as per orders	S.	
		tive uropathy, chronic kidney			Ensuring catheter draina	age	
	disease, and major	depressive disorder.			bag/tubing are positioned off t	he	
					floor		
		mum Data Set (MDS)			How the corrective action(s)		
		0/9/23, indicated the resident			will be monitored to ensure t	the	
		paired for decision making and			deficient practice will not		
		The resident had an indwelling			recur, i.e., what quality		
		eceived an antipsychotic,			assurance programs will be	put	
	antidepressant, and	antiplatelet medications.			into place;		
					Nurse managers will audit 2		
		d on 11/9/23, indicated the			residents with catheters 2 time		
		ry catheter for neurogenic			per week to ensure catheter c	are	
	bladder.				is rendered per orders and		
	TN	1 . 110/0/02			catheter is positioned off the fl		
	-	dated 10/2/23, indicated			The Director of Nursing/design	nee	
	catheter care every	Shift.			will present a summary of the		
	Dharaining - O1	data d 11/12/22 in 3:3			audits to the Quality Assurance		
	-	dated 11/13/23, indicated			committee monthly for 4 mont		
	milliliters (ml).	16 French, balloon size 10			Thereafter, if determined by the		
	minimers (mi).				Quality Assurance committee,		
	The Treetment Adn	ninistration Record (TAR)			auditing and monitoring will be	;	
		care was signed out as being			done quarterly and present quarterly at the QA meeting.		
	completed 11/1-11/				Monitoring will be on going.		
	completed 11/1-11/	10/23.			Date by which systemic		
	Interview with the S	Second Floor Unit Manager on			corrections will be complete	d.	
		n., indicated the foley catheter			12/4/2023	u.	
		n the floor and the nurses			121-112020		
	_	provide catheter care.					
		1					
	3.1-41(a)(2)						
F 0695	483.25(i)						
SS=D	` '	eostomy Care and					
Bldg. 00	Suctioning	-					
-	-	atory care, including					
	- ,,	e and tracheal suctioning.					
	-	ensure that a resident who					

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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 11/20/2023 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 needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. Based on observation, record review, and F 0695 12/04/2023 Munster Med INN interview, the facility failed to ensure oxygen was Annual Survey: 11/20/2023 at the correct flow rate for 1 of 2 residents reviewed for oxygen. (Resident M) Please accept the following as the facility's credible allegation of Finding includes: compliance. This plan of correction does not constitute an During an interview with Resident M on 11/14/23 admission of guilt or liability by the at 11:48 a.m., the resident indicated they wore facility and is submitted only in oxygen all the time. The oxygen flow rate was set response to the regulatory at 2.5 liters per minute. requirement. F695 Respiratory/Tracheostomy On 11/15/23 at 10:09 a.m., and 2:30 p.m., the Care and Suctioning resident was observed wearing oxygen via nasal What corrective action(s) will cannula. The oxygen flow rate was set at 3 liters be accomplished for those per minute. residents found to have been affected by the deficient The record for Resident M was reviewed on practice; 11/16/23 at 11:03 a.m. Diagnoses included, but Resident M- Oxygen flow rate was were not limited to, COPD (chronic obstructive immediately corrected. pulmonary disease), anemia, chronic respiratory How the facility will identify failure, major depressive disorder, high blood other residents having the pressure, anxiety, and dependence on potential to be affected by the supplemental oxygen. same deficient practice and what corrective action will be The 9/29/23 Quarterly Minimum Data Set (MDS) taken: assessment, indicated the resident was All residents receiving oxygen cognitively intact. The resident received oxygen have the potential to be affected as a resident and in the last 7 days she received by the same alleged deficient an anticoagulant medication 7 times. practice. What measures will be put into A Care Plan, revised on 10/23/23, indicated the place or what systemic

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resident had oxygen therapy due to the diagnosis

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changes will be made to

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

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STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER		JILDING	00	COMPLETED	
		155131	B. WI	NG		11/20/	/2023
NAME OF D	DOVIDED OD CUDDI IEE			STREET A	ADDRESS, CITY, STATE, ZIP COD	•	
NAME OF PROVIDER OR SUPPLIER				7935 C	ALUMET AVE		
MUNSTER MED-INN				MUNST	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	TE	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	of COPD.				ensure that the deficient		
		1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1			practice does not recur;		
	-	dated 4/6/23, indicated oxygen			Staff were re-educated on:		
		dminister at 2 liters per minute			Ensuring a physician ord		
	continuously.				is obtained/in-place for oxyger		
	T.,4.,	Second Floor Hold M.			Oxygen is administered	at	
		Second Floor Unit Manager on			the correct liter flow rate.	1	
		n., indicated the resident's			Oxygen tubing is change	ed	
	minute.	e been set at 2 liters per			and labeled appropriately.		
	mmute.				How the corrective action(s)		
	3.1-47(a)(6)				will be monitored to ensure t	ho	
	3.1 17( <b>u</b> )(0)				deficient practice will not	116	
					recur, i.e., what quality		
					assurance programs will be	out	
					into place;	, , ,	
					Nurse Managers will audit 5		
					residents with oxygen 2 times	per	
					week to ensure oxygen is in pl	-	
					and set at the appropriate flow		
					rate.		
					Director of Nursing/designee v	vill	
					present a summary of the aud	its	
					to the Quality Assurance		
					committee monthly for 4 month	hs.	
					Thereafter, if determined by th	e	
					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	d:	
					12/4/2023		
ı l			I				l

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	X2) MULTIPLE CONSTRUCTION (X3) DA		(X3) DATE	DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPI	LETED
		155131	B. W	B. WING 11/20/2023			
				STREET	ADDRESS, CITY, STATE, ZIP COD	<u> </u>	
NAME OF P	ROVIDER OR SUPPLIER	8			ALUMET AVE		
MUNSTE	R MED-INN				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		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
F 0698	483.25(I)						
SS=D	Dialysis						
Bldg. 00	§483.25(I) Dialysis						
	_	ensure that residents who					
		ceive such services,					
	-	ofessional standards of					
		orehensive person-centered e residents' goals and					
	preferences.	residents goals and					
		on, record review, and	F 00	508	Munster Med-Inn		12/04/2023
		ty failed to ensure a dialysis	1.00	) <del>)</del>	Annual Survey: 11/20/2023  Please accept the following as the facility's credible allegation of compliance. This plan of		12/04/2023
		e correct nutritional					
		1 residents reviewed for					
	dialysis. (Resident 1						
	, (				correction does not constitute	an	
	Finding includes:				admission of guilt or liability by		
					facility and is submitted only in	-	
	During random obs	ervations on 11/14/23 at 2:50			response to the regulatory		
	p.m., 11/15/23 at 2:	30 p.m., and 11/16/23 at 3:10			requirement.		
	p.m., there was a co	ontainer of Boost nutritional			F698 Dialysis		
	supplement on Resi	dent 146's over bed table.			What corrective action(s) wil	II	
					be accomplished for those		
		resident on 11/14/23 at 2:50			residents found to have been	n	
	•	goes to dialysis on Tuesdays,			affected by the deficient		
	• •	urdays. The Boost supplement			practice;		
		om the nursing staff at the			Resident 146- Ensure suppler		
		ated she gets them two times a			was immediately removed from		
	day.				resident's bedside. The dialys		
	On 11/17/22 -+ 7 4/	Some the maded ant			dietician was contacted, and r		
		6 a.m., the resident was akfast. At that time, there were			orders were obtained for boos	il	
	_	Boost nutritional supplement			supplement per resident		
	on her over bed table	• •			preference.		
	on her over bed tabl	ic.			How the facility will identify other residents having the		
	The record for Resi	dent 146 was reviewed on			potential to be affected by the	ie.	
		m. Diagnoses included, but were			same deficient practice and		
	_	rtensive chronic kidney			what corrective action will be	e	1
		etes, end stage renal disease,			taken;	-	
		al dialysis, acute kidney failure,			All residents requiring dialysis		
repeated falls, and edema.				services have the potential to be			

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DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-039 X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION STATEMENT OF DEFICIENCIES X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING 00 COMPLETED 155131 B. WING 11/20/2023 STREET ADDRESS, CITY, STATE, ZIP COD

	PROVIDER OR SUPPLIER ER MED-INN	7935 CALUMET AVE MUNSTER, IN 46321				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE  (EACH DEFICIENCY MUST BE PRECEDED BY FULL  REGULATORY OR LSC IDENTIFYING INFORMATION	ID PROVIDERS PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)  TAG DEFICIENCY) DATE				
	The 9/6/23 Quarterly Minimum Data Set (MDS) assessment, indicated the resident was cognitively intact. The resident's vision was adequate with corrective lens. She had no oral problems, weighed 122 pounds, and has had a significant weight loss. The resident received dialysis as a resident  The Care Plan, revised on 10/27/23, indicated the resident required dialysis related to renal failure. The approaches were to provide a house supplement of Nepro 237 milliliters (ml) two times a day.  Physician's Orders, dated 10/10/23, indicated house supplement of Nepro 237 ml two times a day.  Physician's Orders, dated 8/29/23, indicated dialysis every Tuesday, Thursday, and Saturday.  Interview with the Second Floor Unit Manager on 11/17/23 at 8:45 a.m., indicated the resident was to receive the Nepro supplement due to being a dialysis patient.  3.1-37(a)	affected by the same alleged deficient practice.  What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur;  Nursing staff were re-educated on providing supplements as per physician orders.  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;  Nurse Managers will audit 2 dialysis residents being administration supplements 2 times per week to ensure appropriate supplement is provided.  The Director of Nursing/designee will present a summary of the audits to the Quality Assurance committee monthly for 4 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: 12/4/2023				
F 0757 SS=D Bldg. 00	483.45(d)(1)-(6) Drug Regimen is Free from Unnecessary Drugs					

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA  AND PLAN OF CORRECTION IDENTIFICATION NUMBER  155131		(X2) MULTIPLE CO A. BUILDING B. WING	onstruction <u>00</u>	(X3) DATE SURVEY COMPLETED 11/20/2023	
NAME OF PROVIDER OR SUPPLIER  MUNSTER MED-INN			7935 C	ADDRESS, CITY, STATE, ZIP COD CALUMET AVE TER, IN 46321	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
	Each resident's dr from unnecessary drug is any drug w §483.45(d)(1) In eduplicate drug the §483.45(d)(2) For §483.45(d)(3) Withor Sequences which should be reduced §483.45(d)(5) In the consequences which should be reduced §483.45(d)(6) Any reasons stated in (5) of this section. Based on record revialled to manage metholding blood pressidays and checking to the administration medications with Pl 1 of 5 residents review medications. (Resident Finding includes:  The record for Resident The record for Resident The record for Residents review medications, the produced to the same states of the record for Residents review medications. (Residents review medications) (Residents re	excessive dose (including rapy); or excessive duration; or hout adequate monitoring; hout adequate indications he presence of adverse lich indicate the dose dor discontinued; or combinations of the paragraphs (d)(1) through view and interview, the facility edications appropriately related lare medications on dialysis blood pressure and pulse prior in of blood pressure hysician ordered parameters for lewed for unnecessary lent 146)  dent 146 was reviewed on in. Diagnoses included, but were retensive chronic kidney etes, end stage renal disease, al dialysis, acute kidney failure,	F 0757	Munster Med-Inn Annual Survey: 11/20/23  Please accept the following a facility's credible allegation of compliance. This plan of correction does not constitute admission of guilt or liability b facility and is submitted only i response to the regulatory requirement.  What corrective action(s) wi be accomplished for those residents found to have bee affected by the deficient practice; Resident 146's- physician wa	e an y the n II n

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STATEMENT OF DEFICIENCIES X1) PR		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		11/20	/2023
		<u>I</u>		STREET A	ADDRESS, CITY, STATE, ZIP COD	<u> </u>	
NAME OF F	PROVIDER OR SUPPLIEF	₹			ALUMET AVE		
MUNISTE	R MED-INN				ER, IN 46321		
IVIOINGIE				MONST	LIN, IIN HUUZ I		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION	PROVIDER'S PLAN OF CORRECTION	
PREFIX		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
					notified and clarification was		
		ly Minimum Data Set (MDS)			received for blood pressure	_	
	assessment, indicate				parameters and medications t		
	1 -	The resident's vision was			held on dialysis days. Orders	were	
	1 -	ective lens. She had no oral			updated.		
		122 pounds, and has had a			How the facility will identify		
		oss. The resident received			other residents having the	_	
	dialysis as a resider	It.			potential to be affected by th	ie	
	The Core Dian	and on 10/27/22 indicated the			same deficient practice and	_	
		sed on 10/27/23, indicated the alysis related to renal failure.			what corrective action will be	ť	
	resident required di	arysis related to relial fatture.			taken; All facility residents with		
	Physician's Orders	dated 8/29/23, indicated			medication parameters have t	ho	
		day, Thursday, and Saturday.			potential to be affected by the		
	dialysis every rues	day, Thursday, and Saturday.			same alleged deficient practic		
	Physician's Orders	dated 5/23/23, indicated			What measures will be put in		
	1 -	lication used to lower the blood			place or what systemic		
		grams (mg), give 1 tablet three			changes will be made to		
	times a day.	5 (mg/, 51. 5 1 moles unes			ensure that the deficient		
					practice does not recur;		
	Physician's Orders.	dated 7/6/23, indicated			Nurses were in-serviced on		
	1 -	cation used to lower the blood			following blood pressure		
	,	ase the heart rate) 3.125 mg,			parameters as ordered before		
	l ~	morning at bedtime for high			administering medication.		
		y hold the morning dose on		Nurses were in-serviced on h			
		ys, and Saturdays for dialysis.			mediations as per	J	
					orders/administering medication	ons	
	Physician's Orders,	dated 9/16/23, indicated hold			per parameters.		
	blood pressure med	lications on Dialysis days in			How the corrective action(s)		
	the morning every	Tuesday, Thursday, and			will be monitored to ensure t	the	
	Saturday.				deficient practice will not		
					recur, i.e., what quality		
		ministration Record (MAR) for			assurance programs will be	put	
		23, 10/2023 and 11/2023			into place;		
		dilol was administered on 9/16,			Nurse managers will randomly	/	
		26, 9/28, 10/3, 10/5, 10/10, 10/12,			audit 5 residents Medication		
		, 10/26, 10/28, 10/31, 11/2 and			Administration Record (MAR)		
	11/4/23, all of whic	h were dialysis days.			weekly to ensure medications	are	
					being administered/held per		
	The Physician's Ord	der for the Carvedilol was	1		physician parameters.		

CENTERS FOI	R MEDICARE & MEDIC	AID SERVICES				OM	B NO. 0938-039
	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155131	(X2) MULTIPLE CONSTRUCTION       (X3) DATE SURV         A. BUILDING       00       COMPLETED         B. WING       11/20/2023			ETED	
MUNSTE	PROVIDER OR SUPPLIER			7935 C. MUNST	ADDRESS, CITY, STATE, ZIP COD ALUMET AVE ER, IN 46321		
(X4) ID PREFIX TAG	changed on 11/7/23 6.25 mg one time a than 60 and/or syste 100.  The 11/2023 MAR be administered at 9 rate or blood pressu administration of th  Interview with the 9 11/20/23 at 9:00 a.r medications should days as ordered and	Second Floor Unit Manager on m., indicated the blood pressure have been held on dialysis the resident's blood pressure checked prior to the		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)  The Director of Nursing/design will present a summary of the audits to the Quality Assurance committee monthly for 4 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 12/4/2023	ee e e ns. e	(X5) COMPLETION DATE
F 0758 SS=D Bldg. 00	Use §483.45(e) Psych §483.45(c)(3) A partial drug that affects be with mental proce drugs include, but the following cate (i) Anti-psychotic; (ii) Anti-depressar (iii) Anti-anxiety; a (iv) Hypnotic  Based on a comparesident, the facilities §483.45(e)(1) Res	Psychotropic Meds/PRN otropic Drugs. sychotropic drug is any orain activities associated sses and behavior. These are not limited to, drugs in gories:					

unless the medication is necessary to treat a

specific condition as diagnosed and

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DEPARTMEN CENTERS FO		FORM APPROVED OMB NO. 0938-039					
	NT OF DEFICIENCIES I OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155131	(X2) MULTIPLE ( A. BUILDING B. WING	construction 00	(X3) DATE SURVEY COMPLETED 11/20/2023		
NAME OF PROVIDER OR SUPPLIER  MUNSTER MED-INN		R	STREET ADDRESS, CITY, STATE, ZIP COD 7935 CALUMET AVE MUNSTER, IN 46321				
MUNSTER MED-INN		MUNS	51 ER, IN 4032 I				
		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 APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE		
	documented in th						
	reductions, and be unless clinically of to discontinue the §483.45(e)(3) Repsychotropic drugunless that medical a diagnosed specific documented in the §483.45(e)(4) PF drugs are limited provided in §483 physician or presented that it is appropried to the provided beyond document their results.	gs receive gradual dose behavioral interventions, contraindicated, in an effort					
	drugs are limited renewed unless to prescribing pract for the appropriate Based on record refailed to ensure the of a psychotropic to the second results.	RN orders for anti-psychotic to 14 days and cannot be the attending physician or itioner evaluates the resident teness of that medication. Eview and interview, the facility ere was an indication for the use medication for 1 of 5 residents cessary medications. (Resident	F 0758	Munster Med-Inn Annual Survey: 11/20/2023  Please accept the following as facility's credible allegation of compliance. This plan of correction does not constitute a			

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The record for Resident 23 was reviewed on

11/16/23 at 11:00 a.m. Diagnoses included, but

were not limited to, high blood pressure, anemia,

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admission of guilt or liability by the

facility and is submitted only in

response to the regulatory

requirement.

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DEPARTMENT OF HEALTH AND HUMAN SERVICES OMB NO. 0938-039 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 11/20/2023 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 dementia, anxiety, behavior disturbance, insomnia F758 Free from unnecessary and depression. psychotropic meds/PRN use What corrective action(s) will The Quarterly Minimum Data Set (MDS) be accomplished for those assessment, dated 9/28/23, indicated the resident residents found to have been was severely impaired for decision making. In the affected by the deficient last 7 days the resident had received an practice; antidepressant and an antipsychotic medication. Resident 25's- physician was notified and a diagnosis/indication A Care Plan, dated 9/28/23, indicated the resident for use was obtained for displayed physical behavioral symptoms related olanzapine. to hitting a peer. Interventions included, but were How the facility will identify not limited to, refer to psychologist/psychiatrist other residents having the for behavior management as needed. potential to be affected by the same deficient practice and A Physician's Order, dated 5/15/23, indicated for what corrective action will be Olanzapine (antipsychotic medication) 5 taken; milligrams(mg) be administered at bedtime related All residents receiving to dementia. psychotropic medications have the potential to be affected by the A Nurse's Note, dated 11/3/23 at 8:18 a.m., same alleged deficient practice. indicated the resident's gradual dose reduction What measures will be put into (GDR) was contraindicated due to the resident's place or what systemic stable condition on current medication regimen. changes will be made to ensure that the deficient The resident was not seen by the outside practice does not recur; behavioral contracted services. Staff were educated on ensuring there is an appropriate There were no psychologist/psychiatrist progress diagnosis/indication for use for notes to be reviewed. psychotropic medications. How the corrective action(s) Interview with the Director of Nursing on 11/16/23 will be monitored to ensure the at 12:40 p.m., indicated the resident was on an deficient practice will not antipsychotic medication related to a behavior recur, i.e., what quality

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3.1-48(a)(4)

disturbance diagnosis and the resident had not

been seen by any other behavioral services.

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into place;

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assurance programs will be put

Social Services Director/Designee

will randomly audit 5 residents

receiving psychotropic medications weekly to ensure

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

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER			(X2) MULTIPLE CONSTRUCTION (X3) DATE SU. A. BUILDING 00 COMPLET			
		155131	B. WING		11/20	0/2023
	PROVIDER OR SUPPLIE	R	793	EET ADDRESS, CITY, STATE, ZIP 85 CALUMET AVE NSTER, IN 46321	COD	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFI TAG	CROSS-REFERENCED TO THE	N SHOULD BE	(X5) COMPLETION DATE
F 0812 SS=F Bldg. 00	483.60(i)(1)(2) Food Procurement, Stor §483.60(i) Food so The facility must - §483.60(i)(1) - Pr approved or constitution federal, state or left (i) This may includirectly from local applicable State are gulations. (ii) This provision facilities from using gardens, subject applicable safe gulations. (iii) This provision facilities from using gardens, subject applicable safe gulations. (iii) This provision	re/Prepare/Serve-Sanitary safety requirements. cocure food from sources didered satisfactory by bocal authorities. de food items obtained		there is an appropriat diagnosis/indication for The Director of Nursi will present a summa audits to the Quality and the Committee monthly for Thereafter, if determing Quality Assurance consulting and monitoring done quarterly and properties of the QA me Monitoring will be on the Date by which system corrections will be consulted to the Corre	for use. ing/designee ary of the Assurance or 4 months. ined by the ommittee, ing will be resent neeting. going.	

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING COMPLETED 00 B. WING 11/20/2023 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 §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. Based on observation, record review, and F 0812 Munster Med INN 12/04/2023 interview, the facility failed to serve food under Annual Survey: 11/20/2023 sanitary conditions related to beverages being Please accept the following as the uncovered while being transported down the facility's credible allegation of hallway for 1 of 1 meal observations. The facility compliance. This plan of also failed to store and prepare food under correction does not constitute an sanitary conditions related to dried spillage on the admission of guilt or liability by the floor, walls, and door, and a build up of grease facility and is submitted only in and grime on the food preparation equipment for 1 response to the regulatory of 1 kitchens. (The Fourth Floor and the Main requirement. Kitchen) F812 Food Procurement, Store/Prepare/Serve/Sanitary Findings include: What corrective action(s) will be accomplished for those 1. On 11/17/23 at 11:32 a.m., the beverage cart was residents found to have been delivered to the Fourth floor. At 11:50 a.m., a staff affected by the deficient member was observed placing 10 styrofoam cups practice; on the ledge of the nurses' station and filling them Beverages being transported down with juice. the hall were immediately covered appropriately. At 11:52 a.m., staff members were observed Liquid spills were cleaned from placing the uncovered cups on residents' lunch floors, doors, and walls. Grease trays and walking down the hall. and grim was cleaned from the food preparation equipment Interview with the Assistant Director of Nursing including the stove top and fire (ADON) on 11/20/23 at 3:18 p.m., indicated the cups should have been covered. The cup of undated food in the cooler was immediately discarded. The facility policy titled "In-Room Dining" was The convection oven was cleaned provided by the ADON on 11/20/23 at 3:18 p.m. of dried food and grease built up and identified as current. The policy indicated all on top and inside. foods should be covered during transport. 2. How the facility will identify During the initial kitchen tour on 11/14/23 at 8:47 other residents having the a.m. with the Food Service Director, the following potential to be affected by the was observed: same deficient practice and what corrective action will be

a. The stove top and fire irons had a build up of

taken:

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/O		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPL	ETED
		155131	B. WING 11/20/2023			/2023	
		<u>I</u>	1	STREET A	ADDRESS, CITY, STATE, ZIP COD	<u> </u>	
NAME OF P	PROVIDER OR SUPPLIEF	₹			ALUMET AVE		
MUNISTE	R MED-INN				ER, IN 46321		
IVIOINOIE	-1 VIVILUTIININ		-	MONSI	LIN, IIN TOOL 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		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	grease and debris.				All residents have the potentia		
	l				be affected by the alleged def	icient	
	-	of food in the cooler without			practice.		
	dates.				What measures will be put in	ito	
	Tri 1	P 21 20 4 11 1			place or what systemic		
		liquid spillage on the walls by			changes will be made to		
		he floor, and behind the			ensure that the deficient		
	appliances.				practice does not recur;	•	
	d The convention of	oven had dried food and a			Dietary managers/dietary staff		
		on the top and dried food and			were re-educated on:		
	grease build up on t	-			Keeping clean of debris		
	grease build up on	the mside.		such as liquid spills, splashes,		•	
	Interview with the l	Food Service Director on			grease and grim build up.  Keeping convection		
		m., indicated she was working			oven/oven clean		
		lule, job assignments and			Properly labeling/dating	food	
	setting up inservice	-			in cooler	1000	
	setting up inservice	s for the starr.			Staff were educated on:		
	3.1-21(i)(3)				Covering food and bever	rages	
	21(1)(0)				before transporting	lagoo	
					How the corrective action(s)		
					will be monitored to ensure t	he	
					deficient practice will not		
					recur, i.e., what quality		
					assurance programs will be	put	
					into place;	-	
					Administrator/Designee will au	ıdit	
					kitchen 2 times per week to		
					ensure cleanliness/sanitation	of	
					the kitchen areas is maintaine	d.	
					Facility Angel's will audit meal		
					tray pass 3 times per week to		
					ensure food/beverages are co	vered	
					prior to transferring to residen	t	
					rooms.		
					Administrator/designee will		
					present a summary of the aud	its	
					to the Quality Assurance		
					committee monthly for 4 mont	hs.	
					Thereafter, if determined by th	ne	

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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  11/20/2023			
	PROVIDER OR SUPPLIER		793	EET ADDRESS, CITY, STATE, ZIP COD 5 CALUMET AVE NSTER, IN 46321	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION	ID PREFIX TAG	CROSS-REFERENCED TO THE APPR	LD BE COMPLETION
				Quality Assurance commanditing and monitoring we done quarterly and prese quarterly at the QA meeting Date by which systemic corrections will be compared to the property of t	vill be nt ng.
F 0921 SS=E Bldg. 00	§483.90(i) Other E The facility must p sanitary, and com residents, staff an				
	failed to ensure the clean and in good ro marred walls, loose missing tiles, and po	on and interview, the facility residents' environment was epair related to dirty floors, baseboards, lime build up, ersonal care items not floors throughout the facility.	F 0921	Munster Med INN Annual Survey: 11/20/20 Please accept the following facility's credible allegation compliance. This plan of correction does not constant admission of guilt or liability and is submitted or	ng as the n of itute an ity by the
	Maintenance and H	mental tour with the ousekeeping Supervisors on n., the following was observed:		response to the regulator requirement.  F921 Safe/Functional/Sanitary ortable Environment What corrective action(s be accomplished for the	//Comf
	a. On 11/14/23 at 1 observed. The floor accumulation of foo between the beds, the cracked, and the conwere dirty. The reshospital leave.  b. The bathroom fa	0:52 a.m., Room 205 was r mats were dirty, there was an od debris on the floor in ne raised toilet seat was rners of the bathroom floor ident was currently out on uccet in Room 213 had a heavy		residents found to have affected by the deficient practice; Housekeeping was notified cleaning needs for rooms 213, 215, 220, 223, 325, including dirty floors, fauctup, dirty floor mats, soiled nightstand, and soiled be commode.  Maintenance was notified	been ed of : 205, and 329 eet build I dside

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Event ID:

85IL11

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	r í	LTIPLE CO	ONSTRUCTION 00	(X3) DATE S COMPLE	
THIND I DAILY	or condition	155131	B. WIN			11/20/2	
NAME OF I	PROVIDER OR SUPPLIE	R			ADDRESS, CITY, STATE, ZIP COD ALUMET AVE		
MUNSTE	ER MED-INN				ER, IN 46321		
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIE			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
	_	all tile next to the toilet, and the			for repairs needed in rooms: 2		
		in the room. One resident			213, 325, 407, and 408 includ	ing	
		and 3 residents shared the			cracked toilet seat, scratched		
	bathroom.				walls, marred walls, and peeli	ng	
					baseboards.		
		of Room 215, there was a			Resident personal items were		
		wn on the ledge below the			stored/appropriately contained	d.	
		as a urinal on the top ledge			How the facility will identify		
		There was also a pool of water			other residents having the		
		et. Two residents shared the			potential to be affected by th	ie	
	bathroom.				same deficient practice and		
					what corrective action will be	e	
		Room 220 had an accumulation			taken;		
		l was in need of cleaning. Two			All facility residents have the		
	residents resided in	this room.		potential to be affected by the			
					same alleged deficient practic		
		and debris on the floor of Room			What measures will be put ir	nto	
		ght stand also had an			place or what systemic		
		ied spillage. One resident			changes will be made to		
	resided in this room	n.			ensure that the deficient		
					practice does not recur;		
	2. Third Floor				Staff were educated on:		
					Notifying		
		Room 325 was dusty and dirty.			maintenance/environmental		
	The wall by bed 1	was scratched and marred.			services of any necessary rep	airs	
					or cleaning needed.	.	
		nmode in Room 329 for bed 2			Keeping residents' perso		
	had bowel moveme	ent in the container.			items contained/stored proper	-	
					How the corrective action(s)		
	3. Fourth Floor				will be monitored to ensure t	the	
					deficient practice will not		
		bed 2 in Room 407 was			recur, i.e., what quality		
		red. Two residents resided in			assurance programs will be	put	
	the room.				into place;		
					The Maintenance Director will		
		l bed 1 in Room 408 was			audit 5 rooms per week on		
		ed and the baseboard was			alternating units for maintenar	nce	
		the wall. One resident resided			issues. Any issues will be		
	in this room.				corrected.		
		1		Facility Angel's will audit 10			

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

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER		X2) MULTIPLE CONSTRUCTION  A. BUILDING 00  B. WING			(X3) DATE SURVEY  COMPLETED  11/20/2023		
NAME OF PROVIDER OR SUPPLIER  MUNSTER 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	1	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	ΤE	(X5) COMPLETION DATE
	the above were in n	Maintenance and Fat that time, indicated all of eed of cleaning and/or repair.  to Complaint IN00420643.			resident rooms 3 times per we to ensure personal items are contained/stored properly. The Administrator/designee wipresent a summary of the aud to the Quality Assurance committee monthly for 4 montl Thereafter, if determined by th 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 12/4/2023	ill its ns. e	

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