STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155131	A. Building B. Wing	07/03/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Munster Med-Inn	7935 Calumet Ave Munster, IN 46321

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. 45666 Based on record review, and interview, the facility failed to ensure each resident received the necessary treatment and services to promote healing for pressure ulcers, related to ensuring wound care orders were updated and implemented for 1 of 3 residents reviewed for pressure ulcers. (Resident D) Finding includes: Resident D's record was reviewed on 7/2/24 at 9:42 a.m. The resident was discharged to the hospital on 5/28/24. Diagnoses included, but were not limited to, heart failure, chronic obstructive pulmonary disease, and peripheral vascular disease. The Discharge Minimum Data Set assessment, dated 5/28/24, indicated the resident was independent for decision making. She had two stage 3 pressure ulcers and two stage 4 pressure ulcers. A Care Plan, dated 3/26/24, indicated the resident had ulcers to her right heel, bilateral buttocks, and coccyx. Interventions included, but were not limited to, administer treatments as ordered and monitor for effectiveness. A Physician's Order, dated 4/11/24, indicated to cleanse right upper heel with normal saline and/or wound cleanser and apply skin prep to surrounding skin. Apply iodosorb to wound bed and cover with a dry dressing every Monday, Wednesday, Friday, and as needed. A Wound Physician Note, dated 4/18/24, indicated the right heel stage 4 full thickness pressure ulcer measured 1 centimeters (cm) by 0.7 cm by 0.2 cm. The current physician's orders were to continue with the iodosorb gel and dry dressing three times a week. An additional treatment order was placed for a daily oil emulsion. There was no documentation in the record of implementation of the updated orders. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days 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 disclosable 14 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.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155131	A. Building B. Wing	07/03/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Munster Med-Inn	7935 Calumet Ave Munster, IN 46321

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 7/3/24 at 1:16 p.m., the Director of Nursing indicated she was unable to find documentation of an updated treatment order. A policy, titled, Treatment/Services to Prevent/Heal Pressure Ulcers, was provided as current and indicated .1 .b. A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing .5. Interventions will be implemented in the resident's plan of care to prevent deterioration and promote healing of the pressure ulcer. This citation relates to Complaint IN00436912. 3.1-40(a)(2)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155131	A. Building B. Wing	07/03/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Munster Med-Inn	7935 Calumet Ave Munster, IN 46321

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. 45666 Based on record review and interview, the facility failed to ensure gastrostomy tube (peg tube, a tube inserted through the abdomen that allows nutrition to be delivered directly to the stomach) dietary recommendations were followed for 1 of 3 residents reviewed for peg tubes. (Resident H) Finding includes: Resident H's record was reviewed on 7/3/24 at 10:04 a.m. Diagnoses included, but were not limited to, dysphagia (difficulty swallowing), presence of gastrostomy, and aphasia (loss of ability to understand or express speech). The Discharge Minimum Data Set assessment, dated 5/16/24, indicated the resident was severely impaired for daily decision making and had a feeding tube while a resident. A Care Plan, dated 3/26/24, indicated the resident required a tube feeding. Interventions included, but were not limited to, Registered Dietician (RD) to evaluate quarterly and as needed, monitor caloric intake, estimate needs, and make recommendations for changes to the tube feeding as needed. The resident was dependent with tube feedings and water flushes. A Physician's Order, dated 5/24/24, indicated enteral feeding of Glucerna 1.2 (type of enteral feeding)at a rate of 55 ml/hr for 20 hours. The order was discontinued on 6/28/24. An RD Note, dated 6/13/24, indicated the resident was currently receiving Glucerna 1.2 at 55 milliliters per hour (ml/hr) for 20 hours a day with 200 milliliter (ml) water flush every 6 hours. The resident weighed 94 pounds (lbs) on 6/12/24, which was an increase from 92.2 lbs on 5/30/24. The resident had a 8.2% weight loss in the past 30 days, but had a recent above the knee amputation (AKA). A recommendation was made to increase the feeding of Glucerna 1.2 to 65 ml/hr for 20 hours with 200 ml water flush every shift. There was no documentation in the record to indicate the 6/13/24 RD recomendation had been addressed. An RD Note, dated 6/27/24, indicated the resident may benefit from increasing the rate of the tube feeding to better meet estimated nutritional needs. The resident was currently receiving Glucerna 1.2 at 55 ml/hr with 200 ml water flush every 6 hours. A Physician's Order, dated 6/29/24, indicated enteral feeding of Glucerna 1.2 at a rate of 65 ml/hr for 20 hours. During an interview on 7/3/24 at 1:24 p.m., the Director of Nursing indicated any new treatment orders or recommendations from the RD were to be implemented within 72 hours. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155131	A. Building B. Wing	07/03/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Munster Med-Inn	7935 Calumet Ave Munster, IN 46321

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A Policy, received as current and titled, Nutritional Interventions Procedure (NAR), indicated, .2. Residents are considered to be at nutritional risk if they have any of the following conditions: .g. Tube feedings . 5. The Registered Dietician and physician will be notified when nutritional problems are observed and validated, via monthly weights .a. The Charge nurse is responsible for implementing the R.D.'s (Registered Dietician) recommendations after consultation with the attending physician within five (5) working days. This citation relates to Complaint IN00437044. 3.1-44(a)(2)