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	12/05/2024

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 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. 10326 Based on observation, record review, and interview, the facility failed to ensure adequate supervision and assistance were provided to a dependent resident who required total assistance of staff for bed mobility for 1 of 3 residents reviewed for accidents. (Resident B) This deficient practice resulted in a fall and the resident sustained a left femur fracture. Finding includes: A confidential interview indicated Resident B fell out of bed while being repositioned with only one staff member and the resident sustained a leg fracture, the same leg that was fractured during a fall in October 2024. An additional confidential interview indicated the resident was having surgery on 12/4/24 due to re-injuring the left leg. The record for Resident B was reviewed on 12/4/24 at 1:42 p.m. Diagnoses included, but were not limited to, displaced oblique fracture of the shaft of the left femur, vascular dementia with behavior disturbance, type 2 diabetes, protein-calorie malnutrition, and orthopedic aftercare. A Fall Risk Evaluation, dated 10/11/24, indicated the resident was at high risk for falls. The Significant Change Minimum Data Set (MDS) assessment, dated 10/17/24, indicated the resident was cognitively impaired for daily decision making and had range of motion (ROM) impairment to both sides of the lower extremities. The resident was dependent on staff for rolling left and right. Section J - Health Conditions, indicated the resident had a fracture related to a fall in the last six months. The resident was also receiving Physical and Occupational therapies. A Care Plan, dated 9/3/24 and reviewed on 10/17/24, indicated the resident was at risk for falls and injury from falls. Interventions included, but were not limited to, anticipate and meet needs. (continued on next page)

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

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F 0689 Level of Harm - Actual harm Residents Affected - Few	A Nurse's Note, dated 12/3/24 at 7:45 p.m., indicated LPN 1 was called to the room by a CNA. The CNA stated the resident slid to the floor out of the bed while staff was providing care. The resident was seen sitting on the floor on their buttocks next to their bed near the window. There were no visible injuries and no complaints of pain. The resident was not moved and an ambulance was called. At 7:47 p.m. and 7:50 p.m., attempts were made to reach the resident's family. At 7:52 p.m., ambulance staff arrived, pertinent papers were given, and report was given to the emergency room nurse. A Hospital Note, dated 12/4/24 at 7:40 a.m. and completed by the Case Manager, indicated the resident was admitted from the emergency department on 12/3/24. The resident's chief complaint was for evaluation of left leg pain after a fall or near fall at the nursing home. X-rays were obtained of the resident's left femur upon arrival to the hospital. The hospital Radiology Report pertaining to x-ray results of the left femur, dated 12/3/24, indicated the following: 1. Interval development of acute fracture of the subtrochanteric region and proximal diaphysis of the left femur (a type of hip fracture). Post surgical changes again noted. 2. Distal left femoral fracture was present on the study of 10/5/24. On 12/5/24 at 1:30 p.m., the resident's room was observed. Resident B's bed was closest to the window in the room and the bathroom was right next to the room door. The resident had a low air loss mattress (a mattress to prevent and treat pressure ulcers) and two assist rails were at the head of the bed. The fall investigation completed by the facility was dated 12/3/24 and 12/4/24. A statement obtained from QMA 1, on 12/3/24, indicated she was assisting CNA 1 with the resident. She needed more towels for care, and she went to the bathroom to get more towels. When she came out, the resident was sliding off the side of the bed. The QMA ran over and assisted the CNA in guiding the resident to the floor instead of letting them just fall. The resident complained of their knee hurting. The resident was covered up and their back was supported until the ambulance arrived. The resident was in a sitting position. A statement obtained from CNA 1, on 12/3/24, indicated the following, Myself and another staff member went into the patient's room to provide care for the patient, while I was turning the patient to clean her the other staff member was went [sic] to get more towels while the other staff member was doing that I had the patient already turn on her left side. With her legs crossed her hands were on the side rail (enabler). The patient is on a air mattress and started to slide down. I hollered for the other staff member to come help me. I ran to her left side and with my hands and both arms myself and the other staff member lowered her to the floor slowly. Resident was sitting up next to the bed. Nurse immediately notified vital signs were taken. I asked what hurt she stated everything. (sic) During an interview, on 12/4/24 at 2:30 p.m., the Second Floor Unit Manager indicated she was aware of the resident's fall from the night before. She indicated she was told two staff members went into the room to provide care due to the resident being care in pairs. CNA 1 and QMA 1 entered the room to provide care. During care, the QMA went to the bathroom to obtain some towels and the CNA was left at the bedside with the resident and that was when the resident rolled a little and started to slide out of the bed. The Unit Manager indicated CNA 1 was assigned to the resident and she was a float CNA, however, she indicated QMA 1 was familiar with the resident. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	During an interview, on 12/4/24 at 3:10 p.m., CNA 1 indicated she had been assigned to the resident on the evening of 12/3/24. She indicated she was a float CNA and worked as needed (PRN). She also indicated that she was not that familiar with the resident but she did know the resident was care in pairs. The CNA indicated she and QMA 1 entered the room to provide care. During care, the QMA went into the bathroom to get more towels. At that time, the resident was positioned on her left side facing the window. The QMA was on the left side of the bed prior to going to the bathroom to get towels. The CNA indicated she was standing between the two beds in the room and the QMA had been standing at the left side of the bed. The CNA indicated the resident's legs were crossed and the resident started to move their leg and was observed sliding out of the bed. The CNA indicated she yelled for help and ran to the other side of the bed and helped ease the resident to the floor. The resident was in a seated position on the floor with their legs extended and staff supporting their back. During an interview, on 12/5/24 at 2:11 p.m., the Director of Nursing (DON) indicated CNA 1 had reenacted what happened and the CNA made it sound like she was on the same side of the bed as the resident. After reading the CNA's statement, she indicated the CNA was indeed on the opposite side of the bed and had to run around to the other side of the bed to assist the resident. The DON indicated the CNA should have moved to the left side of the resident's bed when the QMA went to the bathroom to get more towels. No policy was provided prior to exit. This citation relates to Complaints IN00448523 and IN 00448529. 3.1-45(a)(2)