

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155131	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/28/2025
NAME OF PROVIDER OR SUPPLIER Munster Med-Inn		STREET ADDRESS, CITY, STATE, ZIP CODE 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)
<p>F 0658</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure services provided by the nursing facility meet professional standards of quality.</p> <p>Based on observation, record review, and interview, the facility failed to ensure professional standards of quality were maintained related to CNAs removing dressings to pressure ulcers and QMAs signing out wound care treatments for 3 of 3 residents reviewed for pressure ulcers. (Residents B, C, and D) Findings include: 1. On 10/27/25 at 1:52 p.m., the Wound Nurse was observed providing wound care for Resident B. She prepared the supplies outside of the resident's room and donned a gown and gloves prior to entering. Upon entering the room, the resident was positioned on his right side and there was no dressing to the sacrum (a triangular bone at the base of the spine). The Wound Nurse indicated the resident had incontinence care completed prior to her entering the room.</p> <p>The Wound Nurse proceeded to treat the area to the sacrum. After the treatment was complete, the Wound Nurse asked for assistance from CNA 1 to complete incontinence care again around the resident's rectal tube.</p> <p>During an interview on 10/27/25 at 2:25 p.m., CNA 1 indicated she had provided incontinence care prior to the resident's wound care. She also indicated the dressing to the sacral wound was soiled so she removed it and let the nurse know.</p> <p>The record for Resident B was reviewed on 10/27/25 at 11:17 a.m. Diagnoses included, but were not limited to, osteomyelitis (bone infection) of the vertebra and sacrococcygeal region and stage 4 pressure ulcer (skin breakdown that involves full-thickness tissue loss exposing underlying structures such as muscle, bone or tendon) of the sacral region.</p> <p>The admission Minimum Data Set (MDS) assessment, dated 9/24/25, indicated the resident was cognitively intact and he was admitted with three unstageable (a type of wound that can't be classified into one of the four pressure ulcers stages due to the presence of slough or eschar) pressure ulcers.</p> <p>A Care Plan, dated 9/20/25, indicated the resident had an ulcer to his right lateral ankle and sacrum. Interventions included, but were not limited to, follow facility policies/protocols for the prevention/treatment of skin breakdown.</p> <p>Physician's Orders, dated 10/22/25, indicated the resident's sacral wound was to be cleansed with normal saline and/or wound cleanser, apply skin prep to the surrounding skin, apply Anasept (an antimicrobial skin and wound care product) soaked gauze to the wound and cover with a dry dressing every day shift and as needed (PRN).</p> <p>During an interview on 10/28/25 at 11:55 a.m., the Director of Nursing indicated the CNA should not have removed the dressing to the resident's sacrum.</p> <p>(continued on next page)</p>

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
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<p>F 0658</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>The current Indiana Nurse Aide Curriculum indicated, the nurse aide would not administer any medications, perform treatment or apply or remove any dressings. Exception to the above would be the application of creams/ointments to intact skin as moisture barrier cream.</p> <p>2. The record for Resident C was reviewed on 10/28/25 at 11:35 a.m. Diagnoses included, but were not limited to, vascular dementia, major depressive disorder, dysphagia, high blood pressure, cardiac pacemaker, atrial fibrillation, and acute kidney failure.</p> <p>The Annual Minimum Data Set (MDS) assessment, dated 9/19/25, indicated the resident was not cognitively intact for daily decision making. The resident had one Stage 3 (a full-thickness skin loss that extends into the subcutaneous tissue but does not involve muscle, tendon, or bone) pressure ulcer, and two Stage 4 pressure ulcers (a severe form of pressure injury that involved full-thickness tissue loss, exposing muscle, tendon, or bone).</p> <p>A Physician's Order, dated 9/13/25, indicated clean the right distal lateral foot with normal saline or wound cleanser, apply skin prep to surrounding skin, apply Anasept and collagen to wound bed, cover with oil emulsion and dry dressing every day shift.</p> <p>A Physician's Order, dated 9/15/25, indicated clean the coccyx wound with wound cleanser or normal saline, apply skin prep to the surrounding skin, apply Hydrofera Blue to the wound bed and cover with a dry dressing every Monday, Wednesday, and Friday.</p> <p>The Treatment Administration Record (TAR) for 9/2025 indicated the following treatments were signed out as being completed by a QMA:</p> <p>Right distal lateral foot: 9/23/25, 9/24/25, 9/26/26, and 9/28/25</p> <p>Coccyx: 9/24/25 and 9/26/25</p> <p>The TAR for 10/2025 indicated the following treatments were signed out as being completed by a QMA:</p> <p>Right distal lateral foot: 10/1/25, 10/7/25, and 10/25/25</p> <p>Coccyx: 10/1/25</p> <p>During an interview on 10/28/25 at 11:00 a.m., the Director of Nursing indicated QMAs were not allowed to perform any pressure ulcer treatments.</p> <p>3. The record for Resident D was reviewed on 10/27/25 at 2:05 p.m. Diagnoses included, but were not limited to, bone cancer, type 2 diabetes, Parkinson's disease, heart failure, psychotic disorder with delusions, adult failure to thrive, and major depressive disorder.</p> <p>The Annual Minimum Data Set (MDS) assessment, dated 8/21/25, indicated the resident was moderately impaired for daily decision making and was dependent on staff for bed mobility. The resident had one stage 4 pressure ulcer (a severe form of pressure injury that involved full-thickness tissue loss, exposing muscle, tendon, or bone) that was not present on admission.</p> <p>(continued on next page)</p>		

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<p>F 0658</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>A Physician's order, dated 9/26/25, indicated to clean the left hip with normal saline or wound cleanser, pat dry, apply skin prep to the surrounding skin, and pack the wound with Dakin's solution moistened gauze and cover with a dry dressing every day and evening shift.</p> <p>A Physician's Order, dated 9/26/25, indicated to clean the left heel with normal saline or wound cleanser, pat dry, apply skin prep to the surrounding skin, and apply Dakin's solution moistened gauze to the wound bed and wrap with kerlix every day and evening shift.</p> <p>The Treatment Administration Record (TAR) for 9/2025 indicated the following treatments were signed out as being completed by a QMA:</p> <p>Left hip</p> <p>Days: 9/26/25 and 9/28/25</p> <p>Evenings: 9/26/25</p> <p>Left Heel</p> <p>Days: 9/26/25 and 9/28/25</p> <p>Evenings: 9/26/25</p> <p>The 10/2025 TAR indicated the following treatments were signed out as being completed by a QMA:</p> <p>Left hip</p> <p>Days: 10/1/25, 10/7/25, and 10/25/25</p> <p>Evenings: 10/3/25, 10/8/25, 10/17/25, and 10/25/25</p> <p>Left Heel</p> <p>Days: 10/1/25, 10/7/25, and 10/25/25</p> <p>Evenings: 10/3/25, 10/8/25, and 10/17/25</p> <p>During an interview on 10/28/25 at 11:00 a.m., the Director of Nursing (DON) indicated QMAs were not allowed to perform any pressure ulcer treatments.</p> <p>During a confidential interview on 10/27/25, a family member indicated they had witnessed QMAs doing pressure ulcer treatments while they were visiting their loved one.</p> <p>The current 9/1/2020 Job Description and Performance Monitoring System for a Qualified Medication Aide (QMA) policy, provided by the DON on 10/28/25 at 2:50 p.m., indicated a QMA can perform minor skin treatments such as a Stage 1 pressure ulcer.</p> <p>3.1-35(g)(1)</p>

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate treatment and care according to orders, resident's preferences and goals.</p> <p>Based on observation, record review, and interview, the facility failed to ensure blood pressure medications were held based on parameters for 1 of 3 residents reviewed for blood pressure parameters. (Resident E) The facility also failed to ensure treatments to skin conditions non-pressure related were completed as ordered for 2 of 3 residents reviewed for pressure ulcers. (Residents D and C) Findings include: 1.The record for Resident E was reviewed on 10/28/25 at 11:13 a.m. Diagnoses included, but were not limited to, heart failure and hypertension.</p> <p>The 10/17/25 Quarterly Minimum Data Set (MDS) assessment indicated the resident was cognitively intact.</p> <p>A current Care Plan indicated the resident was at risk for complications secondary to the diagnosis of hypertension including altered cardiac output and ineffective tissue perfusion. Interventions included, but were not limited to, give antihypertensive medications as ordered.</p> <p>Physician's Orders, dated 10/2/25, indicated the resident was to receive Coreg (a blood pressure medication) 6.25 milligrams (mg) twice a day for hypertension. The medication was to be held if the resident's pulse was less than 60. The resident was also receiving Hydralazine (a blood pressure medication) 100 mg three times a day for hypertension. The medication was to be held if the resident's pulse was less than 60.</p> <p>The October 2025 Medication Administration Record (MAR) indicated the resident received the Coreg when her pulse was below 60 at 6:00 a.m. on 10/3/25, 10/20/25, and 10/21/25.</p> <p>The resident received the Hydralazine when her pulse was below 60 at 6:00 a.m. on 10/3/25, 10/20/25, 10/21/25 and at 1:00 p.m. on 10/3/25.</p> <p>During an interview on 10/28/25 at 11:55 a.m., the Director of Nursing indicated the medications should have been held on the above dates due to the resident's pulse being below 60.</p> <p>2. During an observation on 10/27/25 at 11:00 a.m., Resident D was observed in bed with heel boots to both feet. At that time, CNA 3 was asked to perform incontinence care for him as well as remove the heel boots so the bandages on his feet could be observed. CNA 2 and CNA 3 assisted the resident onto his right side and there was a heavy accumulation of dried and fresh drainage on a left hip bandage. The bandage was not dated and the drainage had leaked all the way to the incontinence pad underneath him. CNA 3 then removed both boots from the resident's feet. There was an undated bandage to the right foot and the left foot was wrapped in an undated kerlix bandage with a moderate amount of dried drainage on the outside by the heel. The resident's feet and legs were very dry and scaly with flakes of skin on the bed linens.</p> <p>During an observation on 10/27/25 at 3:17 p.m., the Wound Nurse was preparing to change the resident's bandages to his left heel and left hip. She washed her hands with soap and water and donned an isolation gown and a clean pair of gloves to both hands. The Wound Nurse removed the bandage from the left hip and there was heavy amount of dried and fresh bloody drainage observed. The wound was pink in color and clean. The resident's feet remained very dry and scaly with flakes of skin still observed in the bed.</p> <p>(continued on next page)</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>The record for Resident D was reviewed on 10/27/25 at 2:05 p.m. Diagnoses included, but were not limited to, bone cancer, type 2 diabetes, Parkinson's disease, heart failure, psychotic disorder with delusions, adult failure to thrive, and major depressive disorder.</p> <p>The Annual Minimum Data Set (MDS) assessment, dated 8/21/25, indicated the resident was moderately impaired for daily decision making and was dependent on staff for bed mobility. The resident had one stage 4 pressure ulcer (a severe form of pressure injury that involved full-thickness tissue loss, exposing muscle, tendon, or bone) that was not present on admission.</p> <p>A Physician's Order, dated 1/31/24, indicated Aquaphor 41% healing ointment, apply to legs and feet topically every evening and night shift. May leave at the bedside for CNA to apply.</p> <p>A Physician's order, dated 9/26/25, indicated to clean the left hip with normal saline or wound cleanser, pat dry, apply skin prep to surrounding skin, and pack the wound with Dakin's solution (an antiseptic wound cleanser) moistened gauze and cover with a dry dressing every day and evening shift.</p> <p>The 10/2025 Treatment Administration Record (TAR) indicated the treatment for the left hip was blank and not signed out on 10/15/25 for the evening shift.</p> <p>The 9/2025 and 10/2025 TARs indicated the Aquaphor cream had been signed out as completed every evening and night shift.</p> <p>The Wound Physician Progress Note, dated 10/23/25, indicated on 10/23/25 the left hip was identified as a surgical wound that dehisced (burst or split open) that measured 4.5 centimeters (cm) in length, 1.1 cm in width, and 1.5 cm in depth. There was undermining of 7 cm at 6 o'clock. The wound bed was 100% granulation tissue (temporary tissue that forms during the wound healing process).</p> <p>During an interview on 10/27/25 at 3:45 p.m., the Wound Nurse indicated the resident's skin was very dry and scaly and she was unaware if he had any cream ordered for the dry skin.</p> <p>During an interview on 10/28/25 at 11:00 a.m., the Director of Nursing indicated the wound and skin treatments should be done as ordered by the physician.</p> <p>3. During an observation on 10/27/25 at 11:41 a.m. the Wound Nurse and the Second Floor Unit Manager were asked to change and provide the treatments to Resident C's pressure and non pressure ulcers. The Wound Nurse washed her hands with soap and water and donned a clean isolation gown and gloves to both hands. She then removed the old and dated, 10/23/25 bandage, from the left lateral knee. The left lateral knee was identified as a skin tear and the area was pink with a small amount of drainage noted. She cleaned and dressed the wound. The Wound Nurse then removed a kerlix bandage from the left hand. The bandage was not dated. There was a piece of foam observed in between the resident's fingers, in which she pulled out and removed. During an interview at that time, she indicated the foam was from the Wound Physician who performed the treatment on 10/23/25. She also indicated the foam was not the oil emulsion bandage that should have been in place and was the current treatment. The wound to the inside of the finger was red and scabbed. She cleaned the wound and palm of the resident's hand with wound cleanser and placed a piece of the oil emulsion bandage in between the resident's fingers where the ulcer was located.</p> <p>(continued on next page)</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview at that time, the Wound Nurse indicated the bandages were old and outdated. The Wound Physician was in the facility on 10/23/25, she did the treatments on that day and those were her initials on the bandages from 10/23/25.</p> <p>The record for Resident C was reviewed on 10/28/25 at 11:35 a.m. Diagnoses included, but were not limited to, vascular dementia, major depressive disorder, dysphagia, high blood pressure, cardiac pacemaker, atrial fibrillation, and acute kidney failure.</p> <p>The Annual Minimum Data Set (MDS) assessment, dated 9/19/25, indicated the resident was not cognitively intact for daily decision making, The resident had one Stage 3 (a full-thickness skin loss that extended into the subcutaneous tissue but did not involve muscle, tendon, or bone) pressure ulcer, and two Stage 4 pressure ulcers (a severe form of pressure injury that involved full-thickness tissue loss, exposing muscle, tendon, or bone).</p> <p>The Care Plan, revised on 10/24/25, indicated the resident had a skin tear to the left finger and palm.</p> <p>A Physician's Order, dated 10/17/25, indicated to clean the left medial first finger with wound cleanser or normal saline, apply skin prep to the surrounding skin, apply oil emulsion to the wound bed and cover with a dry dressing every day shift on Monday, Wednesday, and Friday.</p> <p>A Physician's Order, dated 10/24/25, indicated to clean the left lateral knee wound with normal saline or wound cleanser, pat dry, apply skin prep to the surrounding skin, apply oil emulsion, and cover with a dry dressing every day shift every Monday, Wednesday, and Friday.</p> <p>A Physician's Order, dated 10/25/25, indicated to clean the left palm with wound cleanser or normal saline and apply skin prep.</p> <p>The Treatment Administration Record (TAR) for 10/2025, indicated the treatments to the left lateral knee and left medial first finger were signed out as completed on 10/24/25.</p> <p>During an interview on 10/28/25 at 11:00 a.m., the Director of Nursing indicated the wound and skin treatments should be done as ordered by the physician.</p> <p>This citation relates to Intake 2651009.</p> <p>3.1-37(a)</p>		

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<p>F 0686</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate pressure ulcer care and prevent new ulcers from developing.</p> <p>Based on observation, record review, and interview, the facility failed to ensure pressure ulcers treatments were completed as ordered for 3 of 3 residents reviewed for pressure ulcers. (Residents B, D, and C) Findings include:1.On 10/27/25 at 1:52 p.m., the Wound Nurse was observed providing wound care for Resident B. She prepared the supplies outside of the resident's room and donned a gown and gloves prior to entering. Upon entering the room, the resident was positioned on his right side and there was no dressing to the sacrum (a triangular bone at the base of the spine). The Wound Nurse indicated the resident had incontinence care prior to her entering the room.</p> <p>The Wound Nurse proceeded to clean the sacral wound with Dakin's (an antiseptic solution used to treat wounds) soaked gauze. After cleansing the wound bed, she removed her gloves, donned new gloves, and cleansed the area to the sacrum again with Dakin's soaked gauze. The Wound Nurse then applied skin prep (a protective barrier wipe) to the wound edges and packed the wound bed with Dakin's soaked kerlix gauze and applied a dry dressing.</p> <p>The Wound Nurse then proceeded to treat the area to the resident's right ankle. She cleansed the area with Dakin's soaked gauze, applied skin prep, and then applied Betadine (a topical antiseptic solution).</p> <p>The record for Resident B was reviewed on 10/27/25 at 11:17 a.m. Diagnoses included, but were not limited to, osteomyelitis (bone infection) of the vertebra and sacrococcygeal region and stage 4 pressure ulcer (skin breakdown that involves full-thickness tissue loss exposing underlying structures such as muscle, bone or tendon) of the sacral region.</p> <p>The admission Minimum Data Set (MDS) assessment, dated 9/24/25, indicated the resident was cognitively intact and he was admitted with three unstageable (a type of wound that can't be classified into one of the four pressure ulcers stages due to the presence of slough or eschar) pressure ulcers.</p> <p>A Care Plan, dated 9/20/25, indicated the resident had an ulcer to his right lateral ankle and sacrum. Interventions included, but were not limited to, administer treatments as ordered and monitor for effectiveness.</p> <p>Physician's Orders, dated 10/22/25, indicated the resident's sacral wound was to be cleansed with normal saline and/or wound cleanser, apply skin prep to the surrounding skin, apply Anasept (an antimicrobial skin and wound care product) soaked gauze to the wound and cover with a dry dressing every day shift and as needed (PRN). The resident's right lateral ankle was to be cleansed with normal saline and/or wound cleanser, apply Betadine, and leave open to air every shift.</p> <p>The October 2025 Treatment Administration Record (TAR) indicated the treatments to the sacrum and right lateral ankle were not signed out as being completed on 10/6/25, 10/8/25, and 10/9/25.</p> <p>During an interview on 10/28/25 at 11:55 a.m., the Director of Nursing indicated the treatment orders to the sacrum and right lateral ankle should have been followed and completed as ordered. She also indicated the treatments on 10/6/25, 10/8/25, and 10/9/25 should have been completed as ordered.</p> <p>(continued on next page)</p>		

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<p>F 0686</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>2. During an observation on 10/27/25 at 11:00 a.m., Resident D was observed in bed with heel boots to both feet. At that time, CNA 3 was asked to perform incontinence care for him as well as remove the heel boots so the bandages on his feet could be observed. CNA 2 and CNA 3 assisted the resident onto to his right side and there was a heavy accumulation of dried and fresh drainage on a left hip bandage. The bandage was not dated and the drainage had leaked all the way to the incontinence pad underneath him. CNA 3 then removed both boots from the resident's feet. There was an undated bandage to the right foot and the left foot was wrapped in an undated kerlix bandage with a moderate amount of dried drainage on the outside by the heel.</p> <p>During an observation on 10/27/25 at 3:17 p.m., the Wound Nurse was going to change the resident's bandages. She washed her hands with soap and water and donned an isolation gown and a clean pair of gloves to both hands. She removed the heel boots from both feet and indicated the right foot bandage was there for protection because that wound had recently healed. She used her scissors and cut off the kerlix bandage to the left foot. As she started to remove the bandage, it was adhered to the bottom of the left heel, so she gently used her hands to remove it slowly. Once removed there was a heavy accumulation of dried old brown blood inside the bandage with 2 dried brown bloody gauze sponges. The left heel was red in color with black necrotic (dead) tissue observed. She cleaned the wound with wound cleanser and patted it dry. She opened a package of Skin Prep and used it around the wound, applied Mupirocin ointment (an ointment to treat skin infections) to the wound base, and placed a bordered gauze bandage over the left heel.</p> <p>The record for Resident D was reviewed on 10/27/25 at 2:05 p.m. Diagnoses included, but were not limited to, bone cancer, type 2 diabetes, Parkinson's disease, heart failure, psychotic disorder with delusions, adult failure to thrive, and major depressive disorder.</p> <p>The Annual Minimum Data Set (MDS) assessment, dated 8/21/25, indicated the resident was moderately impaired for daily decision making and was dependent on staff for bed mobility. The resident had one stage 4 pressure ulcer (a severe form of pressure injury that involved full-thickness tissue loss, exposing muscle, tendon, or bone) that was not present on admission.</p> <p>A Care Plan, revised on 9/8/25, indicated the resident had an ulcer to the left heel. The approaches were to treat per the physician's order.</p> <p>A Physician's Order, dated 9/26/25, indicated to clean the left heel with normal saline or wound cleanser, pat dry, apply skin prep to surrounding skin, and apply Dakin's solution (an antiseptic wound cleanser) moistened gauze to the wound bed and wrap with kerlix every day and evening shift. This order was discontinued on 10/24/25 at 5:01 p.m.</p> <p>A Physician's Order, dated 10/24/25, indicated to cleanse the left heel with normal saline or wound cleanser, apply skin prep to the surrounding skin, and apply Mupirocin ointment to the wound bed and cover with a dry dressing every day shift.</p> <p>The 10/2025 Treatment Administration Record (TAR) indicated the treatment for the left heel Dakin's solution moistened gauze was signed out as being completed on 10/24/25 during the day shift. The Mupirocin ointment for the left heel was signed out as being completed on 10/25/25 and 10/26/25.</p> <p>(continued on next page)</p>		

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<p>F 0686</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>The Wound Physician Progress Note, dated 10/23/25, indicated the left heel was identified as a Stage 4 and measured 6.0 cm in length, 3.7 cm in width, and was 0.4 cm in depth. The wound bed was 50% black adherent necrotic (dead) tissue and 50% granulation tissue. The Wound Physician discontinued the Dakin's solution moistened gauze to the left heel and added a new treatment of Mupirocin Topical 2% ointment once daily and as needed.</p> <p>During an interview on 10/27/25 at 3:45 p.m., the Wound Nurse could not verify if the bandages to the left heel had been changed since 10/24/25 because it was wrapped in kerlix and that was the old treatment order for the Dakin's solution. She indicated there was no wound nurse who worked on the weekends and it was up to the floor nurses to complete the treatments. The bandage to the left heel should have been dated after completed.</p> <p>During an interview on 10/28/25 at 11:00 a.m., the Director of Nursing indicated the wound and skin treatments should be done as ordered by the physician.</p> <p>3. During an observation on 10/27/25 at 11:41 a.m., the Wound Nurse and the Second Floor Unit Manager were asked to change and provide the treatments to Resident C's pressure ulcers. The Wound Nurse washed her hands with soap and water and donned a clean isolation gown and gloves to both hands. She removed the old bandage to the right distal lateral and medial foot, dated 10/23/25. There was one large bandage covering both pressure ulcers. The right lateral pressure ulcer was red with fresh bloody drainage, and the right medial pressure ulcer was red with yellow slough (necrotic tissue). She cleaned the right medial foot with wound cleanser and patted it dry. She obtained a Q-tip, and applied the ointments of Anasept (antimicrobial skin ointment) and Collagen to the wound bed and covered the ulcer with a bordered gauze bandage.</p> <p>The record for Resident C was reviewed on 10/28/25 at 11:35 a.m. Diagnoses included, but were not limited to, vascular dementia, major depressive disorder, dysphagia, high blood pressure, cardiac pacemaker, atrial fibrillation, and acute kidney failure.</p> <p>The Annual Minimum Data Set (MDS) assessment, dated 9/19/25, indicated the resident was not cognitively intact for daily decision making. The resident had one Stage 3 (a full-thickness skin loss that extended into the subcutaneous tissue but did not involve muscle, tendon, or bone) pressure ulcer, and two Stage 4 pressure ulcers (a severe form of pressure injury that involved full-thickness tissue loss, exposing muscle, tendon, or bone).</p> <p>A Care Plan, revised on 10/16/25, indicated the resident had pressure ulcers to the right distal lateral and medial foot. The approaches were to administer treatments as ordered by the physician.</p> <p>A Physician's Order, dated 9/13/25, indicated to clean the right distal lateral foot with normal saline or wound cleanser, apply skin prep to the surrounding skin, apply Anasept and collagen to the wound bed, and cover with oil emulsion and dry dressing every day shift.</p> <p>A Physician's Order, dated 10/25/25, indicated to clean the right medial foot with wound cleanser or normal saline, and apply skin prep to the surrounding skin, apply Mupirocin External Ointment 2% and cover with a dry dressing every day shift.</p> <p>(continued on next page)</p>

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NAME OF PROVIDER OR SUPPLIER Munster Med-Inn		STREET ADDRESS, CITY, STATE, ZIP CODE 7935 Calumet Ave Munster, IN 46321	
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<p>F 0686</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>The Treatment Administration Record (TAR) for 10/2025, indicated the treatment for the right lateral foot was signed out as being completed on 10/24/25, 10/25/25, and 10/26/25. The treatment for the right medial distal foot and the Mupirocin was signed out as being completed on 10/25/25 and 10/26/25.</p> <p>A Wound Physician's Note, dated 10/9/25, indicated the right distal lateral foot was identified as a Stage 4 pressure ulcer that measured 1.7 centimeters (cm) in length, by 0.6 cm in width, by 0.3 cm depth. The wound had 30% slough, 30% granulation, and 30% other viable tissue. The right distal medial foot was identified as a deep tissue injury that measured 2 cm in length and 2 cm in width by unmeasurable. The wound was 100% maroon and purple.</p> <p>A Wound Physician's Note, dated 10/13/25, indicated the right lateral foot measured 1.7 cm in length, 1.0 cm in width, and 0.3 cm in depth with 80% granulation and 20% viable tissue.</p> <p>A Wound Physician's Note, dated 10/16/25, indicated the right distal medial foot was 100% intact purple maroon color and measured 2 cm in length and 1.5 cm in width by unmeasurable.</p> <p>A Wound Physician's Note, dated 10/20/25, indicated the right distal lateral foot measured 1.5 cm in length, 1.2 cm in width, and 0.3 cm in depth. The wound bed was 90% granulation tissue and 10% other viable tissue.</p> <p>A Wound Physician's Note, dated 10/23/25, indicated the right medial distal foot measured 2.0 cm in length by 2.5 cm in width by unmeasurable. The wound bed was 60% adhered necrotic black tissue, 20% granulation tissue, and 20% other viable tissue. The treatment was changed to Mupirocin 2% ointment daily and as needed. The right distal lateral foot measured 1.5 cm in length by 1.3 cm in width, by 0.3 cm in depth. The wound bed was 90% granulation tissue and 10% other viable tissue.</p> <p>During an interview on 10/27/25 at 12:35 p.m. the Wound Nurse indicated she was unaware the treatment to the right medial distal foot had changed. She administered the wrong treatment and did not apply the Mupirocin ointment. She indicated the bandages were old and outdated. The Wound Physician was in the facility on 10/23/25 and she did the treatments with him, as those were her initials on the bandages from 10/23/25.</p> <p>During an interview on 10/28/25 at 11:00 a.m., the Director of Nursing indicated the wound and skin treatments should be done as ordered by the physician.</p> <p>This citation relates to Intake 2651009.</p> <p>3.1-40(a)(2)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide and implement an infection prevention and control program.</p> <p>Based on observation, record review, and interview, the facility failed to ensure infection control guidelines were in place and implemented related to not performing hand hygiene before and after glove removal and not wearing personal protective equipment (PPE) while performing wound care for 3 of 3 residents observed for wound care. (Residents B, D, and C) Findings include: 1. On 10/27/25 at 1:52 p.m., the Wound Nurse was observed providing wound care for Resident B. She prepared the supplies outside of the resident's room and donned a gown and gloves prior to entering. She did not sanitize or wash her hands prior to donning the gloves.</p> <p>The Wound Nurse proceeded to clean the sacral wound with Dakin's (an antiseptic solution used to treat wounds) soaked gauze. After cleansing the wound bed, she removed her gloves and donned new gloves without hand sanitizing. She then proceeded to cleanse the wound again with Dakin's soaked gauze. The Wound Nurse then removed her gown and gloves and proceeded to the treatment cart to obtain skin prep pads. She did not sanitize her hands after removing her gown and gloves. After getting the skin prep, the Wound Nurse donned a gown and washed her hands prior to donning gloves. The Wound Nurse then applied skin prep (a protective barrier wipe) to the wound edges after packing the wound with Dakin's soaked gauze. She proceeded to cover the wound with a dry dressing. She removed her gloves, and donned new gloves without hand sanitizing or washing her hands and she added another dressing for reinforcement. After completing the dressing change to the sacrum, she removed her gloves and washed her hands. She donned new gloves and proceeded to cleanse the area to the resident's right ankle with the Dakin's soaked gauze. She realized she didn't have all of the supplies that she needed and she removed her gown and gloves and exited the room. Prior to coming back into the room, the Wound Nurse and CNA 1 donned a gown and gloves before entering. Neither one hand sanitized or washed their hands prior to donning their gloves. The CNA provided incontinence care and the Wound Nurse removed her gown and gloves to get fresh supplies. The Wound Nurse washed her hands before donning her gloves but she did not wear a gown when she came back into the room.</p> <p>The Wound Nurse then proceeded to treat the area to the resident's right ankle. She cleansed the area with Dakin's soaked gauze, removed her gloves and applied new gloves without hand sanitizing or washing her hands. She applied the skin prep to the wound and then applied Betadine (a topical antiseptic solution).</p> <p>During an interview on 10/28/25 at 11:55 a.m., the Director of Nursing (DON) indicated the Wound Nurse should have either washed her hands or used hand sanitizer before and after glove removal. The DON also indicated the Wound Nurse should have worn a gown during the treatment to the right ankle due to the resident requiring enhanced barrier precautions (EBP).</p> <p>The facility policy regarding Enhanced Barrier Precautions (EBP) was provided by the Director of Nursing on 10/28/25 at 2:00 p.m. The policy indicated EBP referred to an infection control intervention designed to reduce transmission of multidrug-resistant organisms that employed targeted gown and glove use during high contact resident care activities.</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>2. During an observation on 10/27/25 at 3:17 p.m., the Wound Nurse was going to change Resident D's bandages. She washed her hands with soap and water and donned an isolation gown and a clean pair of gloves to both hands. She removed the heel boots from both feet and used her scissors and cut off the kerlix bandage to the left foot. As she started to remove it, it was adhered to the bottom of the left heel, so she gently used her hands to remove it slowly. The Wound Nurse removed her gloves and donned clean gloves to both hands and did not perform hand hygiene. She cleaned the wound with wound cleanser, patted it dry and removed her gloves and donned clean gloves to both hands and did not perform hand hygiene. She opened a package of Skin Prep and applied it around the wound, applied Mupirocin (an ointment to treat skin infections) ointment to the wound base, and placed a bordered gauze bandage over the left heel. She removed her gloves and washed her hands with soap and water. The Wound Nurse then removed the bandage from the left hip and there was a heavy amount of dried and fresh bloody drainage observed. She removed her gloves and donned a pair of clean gloves to both hands and did not perform hand hygiene.</p> <p>During an interview on 10/27/25 at 3:45 p.m., the Wound Nurse indicated she was unaware she had to perform hand hygiene every time she removed her gloves.</p> <p>During an interview on 10/28/25 at 11:00 a.m., the Director of Nursing indicated hand hygiene was to be performed before and after glove removal.</p> <p>3. During an observation on 10/27/25 at 11:41 a.m., the Wound Nurse and the Second Floor Unit Manager were asked to change and provide the treatments to Resident C's pressure ulcers. The Wound Nurse washed her hands with soap and water and donned a clean isolation gown and gloves to both hands. She removed the old bandage to the right distal lateral and medial foot. She removed her gloves, washed her hands with soap and water, and donned clean gloves to both hands. The Wound Nurse cleaned the pressure ulcer to the right distal lateral foot with wound cleanser, patted it dry, removed her gloves, donned clean gloves to both hands and did not perform hand hygiene. She performed the treatment to the lateral foot, removed her gloves and performed hand hygiene. She donned a clean pair of gloves to both hands, and cleaned the right distal medial foot wound with wound cleanser, patted it dry, and removed her gloves, donned clean gloves to both hands and did not perform hand hygiene. She put the ointments on the wound bed, removed her gloves, donned clean gloves to both hands and did not perform hand hygiene. She then covered the wound with a piece of oil emulsion bandage and secured it with a dry bordered bandage. She removed her gloves, washed her hands with soap and water, and donned clean gloves to both hands. She removed the bandage from the coccyx pressure ulcer, discarded her gloves, donned a clean pair of gloves to both hands and did not perform hand hygiene. She cleaned the wound with wound cleanser, patted it dry, removed her gloves, donned clean ones, and did not perform hand hygiene. She completed the treatment and performed hand hygiene. She donned clean gloves to both hands, and removed the bandage from the left lateral knee. She discarded the old gloves, donned clean gloves to both hands and did not perform hand hygiene. She cleaned the wound, removed her gloves, donned clean gloves and did not perform hand hygiene and proceeded to the complete the treatment. She performed hand hygiene, donned clean gloves to both hands and removed the kerlix bandage from the resident's left hand. She then removed her gloves, donned clean gloves and did not perform hand hygiene. She cleaned the wound and palm of the resident's hand, discarded her gloves, donned clean gloves and did not perform hand hygiene and completed the treatment.</p> <p>During an interview on 10/27/25 at 3:45 p.m., the Wound Nurse indicated she was unaware she had to perform hand hygiene every time she removed her gloves.</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 10/28/25 at 11:00 a.m., the Director of Nursing (DON) indicated hand hygiene was to be performed before and after glove removal.</p> <p>The current 9/1/2020 Hand Hygiene/Handwashing policy, provided by the DON on 10/28/25 at 2:50 p.m., indicated hand hygiene was to be performed before and after glove removal.</p> <p>3.1-18(b)</p>		