STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155131	A. BUILDING _____ B. WING _____	**10/14/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
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 0773 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Provide or obtain laboratory tests/services when ordered and promptly tell the ordering practitioner of the results.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to obtain Physician's Orders related to COVID-19 mandatory mass resident testing due to a facility outbreak for 2 of 3 residents reviewed for Infection Control. (Residents 3 and 4) Findings include: 1. The record for Resident 3 was reviewed on 10/14/20 at 12:00 p.m. The resident was admitted to the facility on [DATE]. The facility conducted COVID-19 outbreak testing on 9/22, 9/29, and 10/13/20. The resident did not have a Physician's Order to be tested for COVID-19. Interview with the Director of Nursing on 10/14/20 indicated the resident did not have a written order to be tested when facility outbreak testing was completed and a standing order would be obtained. 2. The record for Resident 4 was reviewed on 10/14/20 at 12:30 p.m. The resident was admitted to the facility on [DATE]. The facility conducted COVID-19 outbreak testing on 9/22, 9/29, and 10/13/20. The resident did not have a Physician's Order to be tested for COVID-19. Interview with the Director of Nursing on 10/14/20 indicated the resident did not have a written order to be tested when facility outbreak testing was completed and a standing order would be obtained. The CMS Memorandum, dated 8/26/20, indicated the facility must obtain an order from a physician, physician assistant, nurse practitioner, or clinical nurse specialist in accordance with State law, including scope of practice laws to provide or obtain laboratory services for a resident, which includes COVID-19 testing . 3.1-49(f)(1)
F 0880 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Many	**Provide and implement an infection prevention and control program.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, and interview, the facility failed to ensure infection control guidelines were in place and implemented to properly prevent and/or contain COVID-19 related to personal protective equipment (PPE) not worn properly with resident interaction, improper mask use, isolation signs not posted during random observations for infection control and not suspending indoor visitation during a facility COVID-19 outbreak on 5 of 5 floors. (The First, Second, Third, Fourth and Fifth floors) Findings include: 1. During a random observation, on 10/14/20 at 9:12 a.m., Social Worker 1 was seated at her desk in her office with the door open. She was not wearing a mask at the time and Social Worker 2 was standing next to her. Social Worker 2 had her mask hanging from her ear. The staff members were not standing six feet apart. Interview with Social Worker 2 at the time, indicated the office was too small to social distance. Interview with the Director of Nursing on 10/14/20 at 12:10 p.m., indicated both of the Social Service staff members should have been wearing their masks. 2. During a random observation on 10/14/20 at 9:40 a.m., Physical Therapy Aide (PTA) 1 was seated at the desk talking to another staff member, she had her mask pulled down around her chin. Physical Therapist 1 was seated at another desk at the time, he was not wearing a mask. Interview with the Director of Nursing on 10/14/20 at 12:10 p.m., indicated the Physical Therapist should have been wearing a mask. 3. During a random observation on 10/14/20 at 9:18 a.m., a stop sign was on the door of room [ROOM NUMBER] and an isolation set up was present. The stop sign had personal protective equipment (PPE) listed at the bottom of the sheet and the items which needed to be worn were circled. The sheet did not indicate the type of isolation. Interview with QMA 1 at the time, indicated the resident was in droplet precautions. Interview with the Third Floor Unit Manager on 10/14/20 at 9:22 a.m., indicated the resident was in contact precautions due to a wound infection. Interview with the Director of Nursing on 10/14/20 at 2:15 p.m., indicated a sign should have been posted on the door indicating what type of isolation. 4. During random observations on 10/14/20 from 9:15 a.m., to 10:00 a.m. on the First, Second, Third, Fourth, and Fifth floors, direct care staff were not observed wearing any protective eyewear when coming in close contact with all residents regardless of if they were in transmission based precautions or not. Interview with CNA 1 on 10/14/20 at 9:30 a.m., indicated she worked on the 5th floor on a routine basis. She would only wear a face shield or goggles if a resident was in isolation. She did not wear face shields or goggles when giving ADL care or giving showers. Observation on the Fourth floor at 9:30 a.m., indicated there was a designated COVID-19 area on the even hall. At that time, there were 2 residents who were positive for COVID-19 and were isolated in transmission based precautions (TBP) on the hall. Interview with the Fourth Floor Unit Manager on 10/14/20 at 9:35 a.m., indicated the staff were only wearing protective eyewear in the TBP rooms. Interview with CNA 2 on 10/14/20 at 9:37 a.m., indicated she was taking care of the COVID-19 residents as well as 10 other residents. She did not wear protective eyewear when providing showers or providing ADL care for the other residents. On 10/14/20 at 9:41 a.m., a housekeeper was observed cleaning a bathroom and toilet in a resident room. The resident was not on transmission based precautions. The housekeeper was wearing a facemask over her nose and mouth, however, she had no protective eyewear covering her face in case of splashes. Interview with the Director of Nursing on 10/14/20 at 10:00 a.m., indicated she was unaware face shields were to be worn by all staff for all residents when encountering splashes or spills. The facility had 2 residents who were positive for COVID-19. An Indiana Department of Health memo, dated 9/2/20, indicated To align with updated Centers for Disease Control and Prevention (CDC) guidelines, Indiana Department of Health is now recommending the use of eye protection as a standard safety measure to protect long-term care (LTC) healthcare personnel (HCP) who provide essential direct care within 6 feet of the resident, especially when doing procedures that lead to sprays and splashes. High-risk examples include assistance in showers, tub rooms, salons, assistance in toileting, hygiene, changing linens, and environmental cleaning. Some lower-risk examples are giving meds (medications) or glucose monitoring, dropping off meals. This includes the delivery of care for non-COVID residents in facilities with 1 or more symptomatic and/or COVID positive residents, and those who are quarantined in COVID positive, symptomatic, or quarantined residents who are already in transmission-based precautions -Droplet-Contact. 5. On 10/14/20 9:14 a.m., room [ROOM NUMBER] had an isolation set up on the door. There was no sign on the door to indicate what type of isolation. Interview with the LPN 1 at that time, indicated the resident was in contact isolation for shingles and confirmed there was no sign on the door. 6. During an observation on 10/14/20 from 10:00 a.m., to 11:00 a.m., indoor visitation was held in the family dining room area. There were 5 different families and they were all socially distanced from the residents. The visitation last approximately 1 hour and then the families left the facility. The timeline of events, provided by the Director of Nursing (DON) on 10/14/20 at 10:00 a.m., was as follows: - Outbreak status for the facility began on 9/17/20 when 3 staff member tested positive for COVID-19, 1 of 3 was direct care staff, their entire resident line up was placed in TBP (Transmission Based Precautions) - Testing was done for all residents on 9/22/20 and 2 residents on that line up tested positive and were moved to the COVID-19 unit. 1 of those residents was a repeat positive after 90 days of first positive. - On 9/24/20 all staff were tested and were all negative. - On 9/29/20 all residents were tested and 1 resident tested positive (already in isolation due to being exposed from 9/17/20) and was moved to the COVID-19 unit. - On 10/1/20 all staff were tested , and all were negative. - On 10/6/20 all residents were tested and all were negative. - On 10/8/20 all staff

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

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.

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F 0880 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Many	(continued... from page 1) were tested . There was 1 positive therapist. All residents in her caseload were placed on TBP. - On 10/13/20 all residents tested with the results still pending. - 10/15/20 all staff to be tested . Interview with the DON on 10/14/20 at 11:40 a.m., indicated on 9/29/20, a new resident tested positive and on 9/30/20 she was admitted to the hospital. The facility had continued with indoor visitation during the last 14 days even after the resident tested positive on 9/29/20. Indoor visitation had been going on the entire month of September 2020. An Indiana Department of Health memo, dated 9/23/20, indicated Indoor Visitation was permitted to resume as of July 4. As of July 17, waiver guidelines were updated to require four hours per day of visitation, including evening hours, if there has not been a new facility-onset COVID-19 case in 14 days. A facility can therefore create a policy for length of visits, the number of visitors per resident, and the number of visitors at any one time. Consideration should be given to staffing availability, PPE stocks, and resident needs . Other requirements include - There have been no new facility-onset COVID-19 resident cases in the past 14 days. 3.1-18(b)(1)