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No. 0938-0391

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 01/28/2026
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)
F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. Based on record review and interview the facility failed to implement measures to prevent resident-to-resident verbal and physical abuse to a cognitively impaired dependent resident (Resident C) by his roommate (Resident B), who had a history of behaviors and recent verbal abuse toward Resident C, resulting in a physical altercation where Resident B struck Resident C in the face causing observed bruising, a bloody nose and swelling to his left jaw and cheek as well as facial fractures for 2 of 8 residents reviewed for abuse. The immediate jeopardy began on 12/11/25 when a resident with a history of known physical and verbal behaviors was involved in a resident-to-resident verbal altercation with his roommate, which later escalated on a different day into a resident-to-resident physical altercation causing harm and a fractured facial bone. The Administrator, Director of Nursing, [NAME] President of Operations, and Nurse Consultant were notified of the immediate jeopardy at 5:20 p.m. on 1/27/26. The immediate jeopardy was removed, and the deficient practice corrected on 12/29/25, prior to the start of the survey, and was therefore Past Noncompliance.Finding includes: a. The record for Resident B was reviewed on 1/22/26 at 9:40 a.m. Diagnoses included, but were not limited to, vascular dementia with behaviors, chronic kidney disease stage 4, traumatic subdural hemorrhage (brain bleed), hemiplegia (weakness) on the right side, delusional disorder, intellectual disabilities, psychotic disorder with delusions, and anxiety.The 9/2/25 Quarterly Minimum Data Set (MDS) assessment indicated the resident had no behaviors and was moderately impaired for daily decision making. A Behavior Note, dated 10/9/25 at 10:46 a.m., indicated the resident was observed ambulating around his room without assistance. The staff responded to the resident and tried to assist him to the wheelchair, as he became verbally aggressive with staff, yelling and threatening them. A Behavior Note, dated 10/15/25 at 3:37 a.m., indicated the resident got out of bed again. While attempting to assist him back to bed, he grabbed the staff's wrist and squeezed it hard. A Behavior Note, dated 10/16/25 at 1:57 p.m., indicated the resident was sitting in the dining room and started yelling aggressive words across the room. A Behavior Note, dated 11/3/25 at 9:18 a.m., indicated the resident was being pulled up in bed by 2 CNAs and spit on both. The Annual MDS assessment, dated 11/12/25, indicated the resident was moderately impaired for decision making. The resident had little interest in doing things, felt down and tired, and had trouble concentrating. The resident had not displayed any hallucinations or delusions, but had physical, verbal and other behaviors that occurred in the last 1 to 3 days during the assessment reference period. The resident's behaviors significantly interfered with care and activities and had an impact on others of significant risk of physical injury, disruption of care and the living environment. The resident's behaviors had worsened since last assessment, and he needed substantial to max assist with transfers. The resident received antipsychotic, antianxiety, antidepressant, and anticonvulsant medications. A Care Plan, revised on 11/20/25, indicated the resident displayed verbal behavioral symptoms not directed toward others as evidenced by yelling and using profanity towards self. The approaches were to separate the (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

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	resident from others as needed. A Care Plan, revised on 11/20/25, indicated the resident was at risk for complications related to receiving antipsychotic medications due to behavior management. The approaches were to monitor/record occurrence of for target behavior symptoms (Specify: pacing, wandering, disrobing, inappropriate response to verbal communication, violence/aggression towards staff/others. etc.) and document per facility protocol. A contracted Behavioral Nurse Practitioner (NP) note, dated 11/5/26 at 11:00 p.m., indicated they received a call from social service regarding the resident and he continued to exhibit more agitated behaviors and fluctuation in mood. The medication of Depakote (an anticonvulsant used for mood disorders) would be restarted as it was previously discontinued as part of a gradual dose reduction. A Behavior Note, dated 11/6/25 at 11:21 a.m., indicated the resident was observed spitting on staff during care. A Behavior Note, dated 11/28/25 at 3:45 p.m., indicated the resident was observed in activities. At that time, he started to yell an outburst about killing. The resident was moved to a different seat but the outbursts and yelling continued. He was moved to the hallway. There was no other documentation or interventions done after the resident had the outburst about killing. A Medication Administration note, dated 12/3/25 at 11:12 p.m., indicated the resident was yelling at roommate while roommate was sleeping, prn (as needed) Lorazepam (an antianxiety medication) 0.5 milligrams (mg) given for agitation and anxiety. A Medication Administration note, dated 12/5/25 at 1:28 a.m., indicated the resident was yelling at roommate, prn Lorazepam 0.5 milligrams given for agitation and anxiety. A Behavior Note, dated 12/11/25 at 2:38 a.m., indicated, Writer heard resident yelling, went in to check on resident. Resident was standing up hovering over roommate yelling. CNAs and writer assisted resident back into bed, PRN lorazepam given. Resident in bed relaxing, safety measures in place. There were no additional interventions put into place and Resident B was not moved to another room after he was observed yelling and hovering over Resident C on 12/11/25. An Incident Note, dated 12/28/25 at 11:10 p.m., indicated Resident was involved in a physical altercation with his roommate. Residents were separated and body assessment completed. [Resident B] has no injuries. Resident was placed on 1:1 supervision. Resident sister and MD were notified and orders received to transfer resident to emergency room for psych evaluation. Report called in to ER nurse. (sic) A Nurses' Note, dated 12/29/25 at 2:42 p.m., indicated Resident B would be transferred to a neuro psych hospital by ambulance in 30 minutes. The facility IDOH (Indiana Department of Health) incident report, dated 12/28/25, indicated Resident B and Resident C were in a physical altercation, both were immediately separated. The nurse assessed Resident C and he was noted with facial bruising/discoloration and some bleeding from his nose. Resident B had no injuries; however, both residents were sent to the emergency room. The police, physician, and family were all notified. The follow up investigation indicated both residents resided in the memory care unit and were roommates. The incident was not witnessed, however upon entering the room the CNA observed Resident B to have blood on his clothing and Resident C had blood around his nose with redness and discoloration to the side of his face. Resident C could not initially articulate what had happened, however, upon re-questioning, admitted something had occurred but indicated his roommate did not want to speak about it. Review of the facility's investigation indicated all staff on shift at the approximate time of the incident were interviewed. It was determined that staff provided care to both residents at approximately 9:45 p.m., and both residents were resting quietly in bed. At approximately 11:10 p.m., the CNA was doing initial rounds after shift change and found the residents in the above-mentioned condition. Both residents were sent to the hospital, and Resident C sustained a depressed fracture involving the anterior wall of the left maxilla (upper jawbone) and associated maxillary hemorrhage (bleeding). He returned to the facility that day, and Resident B was transferred to an inpatient (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	neuro psych facility. A facility documented interview from CNA 1 indicated changed both of them on 8 am and 8:30 pm, had a family emergency and had to leave around 10:30 pm, heard loud yelling from a male voice stating something like turn off the light I did not know who it was and I was in the lounge area did not think anything of it due to residents yelling all the time. (sic)A facility documented interview from LPN 1 indicated I started working that side about 8 pm when other nurse left. Did not see much of them during the shift. Right at shift change Resident B yelled out something but I could not make out what happened, it was like jibberish [sic]. He was in his room. I am not sure if the aide went to his room, but I did not. I never saw him display any aggressive behavior toward staff for residents. The other nurse gave his meds. I was in the hallway around 10 pm. There were still residents up in the dining room, so we were getting them together to go to bed. Resident B is known to yell out. The police report, dated 12/28/25 at 11:19 p.m., indicated responded to call from the facility in reference to assault that just occurred. They called stated that one of the residents attacked his roommate. The victim was observed laying [sic] in bed with a bloody face and multiple bruises and swelling to the face and mouth area. He was unaware of what happened due to reported dementia . The incident occurred between 10 p.m. and 11 p.m.A CAT scan (diagnostic imaging test using X-rays and a computer to create detailed 3D pictures of bones, organs, and tissues) of the facial bones was completed at the hospital for Resident C on 12/29/25. The impression was 6 mm (millimeter) depressed fracture involving the anterior wall of the left maxilla (upper jawbone/cheek) with associated maxillary hemorrhage (bleeding). b. The record for Resident C was reviewed on 1/27/26 at 12:05 p.m. Diagnoses included, but were not limited to, dementia, anxiety, and Alzheimer's Disease. The 11/14/25 Quarterly MDS assessment indicated the resident was not cognitively intact for daily decision making and needed substantial to max assist with ADLs. During an interview on 1/27/26 at 2:00 p.m., the Director of Nursing indicated she was not aware of the incident that happened on 12/11/25. She indicated staff were to report to her or the Administrator of any new or worsening behaviors. During an interview on 1/27/26 at 2:00 p.m., the Nurse Consultant indicated she was unaware of the incident that happened on 12/11/25 as well and staff were to report any new behaviors a resident exhibited. The behavior policy had not changed, and it was the same one in place when both incidents happened. Staff were inserviced regarding behavior reporting during all staff meetings and were also assigned some computer training. There was no 5th Floor Unit Manager during both incidents and the unit managers on floors one through four were all overseeing some aspect of resident care for the fifth floor. The Memory Care Director was also to oversee behaviors. During an interview on 1/27/26 at 2:20 p.m., the Memory Care Director indicated she was not aware of the incident on 12/11/25 when Resident B was observed yelling and hovering over Resident C in their room. She indicated staff were to let her know of any type of behavior any of the residents displayed. During an interview on 1/28/26 at 3:30 p.m., CNA 1 indicated she was taking care of Resident B and Resident C on 12/28/25. She told the nurse she received many phone calls from home and had to leave early at 10:30 p.m., due to a family emergency. It was her first time working on the memory care unit, so she was not familiar with any of the residents. She was told by other staff that Resident B yells out all the time. She checked on all her residents before she left and that was before 10:00 p.m. She was in the lounge (located right across from Residents B and C's room) on the phone with her family and she heard Resident B yelling, however, the nurses were in the hallway, so she did not feel she had to get up and check on him, because they were standing right there, so she remained on the phone with her family dealing with the emergency. The current 12/31/24 Behavior Management policy, provided by the Assistant Administrator on 1/27/26 at 9:00 a.m., indicated when a resident exhibited behaviors, it was the responsibility of (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	the staff member that witnessed the behavior to report it to the resident's care staff and document the behavior accordingly. If the behavior was disruptive to others, the resident should be temporally separated from others.The current 9/1/24 Abuse Prevention and Reporting policy, provided by the Assistant Administrator on 1/27/26 at 9:00 a.m., indicated the resident had the right to be free from abuse and neglect. Any incident or allegation involving abuse or neglect will result in an investigation and should be documented. All alleged violations involving abuse or neglect were reported to the Administrator immediately but not later than two hours after the allegation was made. The past noncompliance immediate jeopardy began on 12/11/25. The immediate jeopardy was removed and the deficient practice corrected by 12/29/25 after the facility implemented a systemic plan that included the following actions: The facility immediately put a plan of correction into place and had a quality assurance meeting with the department heads. All staff were then inserviced on the different types of abuse and reporting abuse. Staff were also inserviced on the behavior management program for any resident with new or worsening behaviors and when and who to report those behaviors. The residents were separated and Resident B returned to a private room on a different floor. This citation relates to Intakes 2698383, 2704995, 2705043, and 2710478.3.1-27(a)(1)

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F 0609 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. Based on record review and interview, the facility staff failed to report resident-to-resident verbal abuse from a resident with known behaviors (Resident B) towards his roommate (Resident C) to administration, which resulted in a lack of interventions to prevent later physical abuse for 2 of 8 residents reviewed for abuse. (Residents B and C) The immediate jeopardy began on 12/11/25 when a resident with a history of known physical and verbal behaviors was involved in a resident-to-resident verbal altercation with his roommate, which later escalated on a different day into a resident-to-resident physical altercation causing harm and a fractured jawbone. The Administrator, Director of Nursing, [NAME] President of Operations, and Nurse Consultant were notified of the immediate jeopardy at 5:20 p.m., on 1/27/26. The immediate jeopardy was removed, and the deficient practice corrected, on 12/29/25, prior to the start of the survey and was therefore Past Noncompliance. Finding includes:The record for Resident B was reviewed on 1/22/26 at 9:40 a.m. at 9:40 a.m. Diagnoses included, but were not limited to, vascular dementia with behaviors, chronic kidney disease stage 4, traumatic subdural hemorrhage (brain bleed), hemiplegia (weakness) on the right side, delusional disorder, intellectual disabilities, psychotic disorder with delusions, and anxiety.The 9/2/25 Quarterly Minimum Data Set (MDS) assessment indicated the resident had no behaviors and was moderately impaired for daily decision making. The Annual MDS assessment, dated 11/12/25, indicated the resident was moderately impaired for decision making. The resident had little interest in doing things, felt down and tired, and had trouble concentrating. The resident had not displayed any hallucinations or delusions, but had physical, verbal and other behaviors that occurred in the last 1 to 3 days during the assessment reference period. The residents' behaviors significantly interfered with care and activities and had an impact on others of significant risk of physical injury, disruption of care and the living environment. The resident's behavior had worsened since last assessment, and he needed substantial to max assist with transfers. The resident received antipsychotic, antianxiety, antidepressant, and anticonvulsant medications. A Care Plan, revised on 11/20/25, indicated the resident displayed verbal behavioral symptoms not directed toward others as evidenced by yelling and using profanity towards self. The approaches were to separate the resident from others as needed. A Care Plan, revised on 11/20/25, indicated the resident was at risk for complications related to receiving antipsychotic medications due to behavior management. The approaches were to monitor/record occurrence of for target behavior symptoms (Specify: pacing, wandering, disrobing, inappropriate response to verbal communication, violence/aggression towards staff/others. etc.) and document per facility protocol. A Medication Administration note, dated 12/3/25 at 11:12 p.m., indicated the resident was yelling at roommate while roommate was sleeping, prn Lorazepam (an anti-anxiety medication) 0.5 milligrams (mg) given for agitation and anxiety. A Medication Administration note, dated 12/5/25 at 1:28 a.m., indicated the resident was yelling at roommate, prn Lorazepam 0.5 milligrams (mg) given for agitation and anxiety. A Behavior Note, dated 12/11/25 at 2:38 a.m., indicated Writer heard resident yelling, went in to check on resident. Resident was standing up hovering over roommate yelling. CNAs and writer assisted resident back into bed, PRN lorazepam given. Resident in bed relaxing, safety measures in place. There were no new interventions, and Resident B was not moved to another room after he was observed yelling and hovering over Resident C. There were no documented notifications to the Director of Nursing, Administrator or charge nurse or interventions implemented after all the above incidents. Both residents remained in the same room. An Incident Note, dated 12/28/25 at 11:10 p.m., indicated Resident was involved in a physical altercation with his roommate. Residents were separated and body assessment completed. [Resident B] has no injuries Resident was placed on 1:1 supervision. (continued on next page)

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F 0609 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Resident sister and MD were notified and orders received to transfer resident to emergency room for psych evaluation. Report called in to ER nurse. (sic) Per the facility investigation, Resident C was sent to the hospital and diagnosed with a depressed fracture involving the anterior wall of the left maxilla (upper jawbone) and associated maxillary hemorrhage (bleeding).Cross reference F600. During an interview on 1/27/26 at 2:00 p.m., the Nurse Consultant indicated she was unaware of the incident that happened on 12/11/25 as well and staff were to report any new behaviors a resident has. The behavior policy had not changed, and it was the same one in place when both incidents happened. Staff were inserviced regarding behavior reporting during all staff meetings and had additional computer training. There was no 5th Floor Unit Manager during both incidents and the unit managers on floors one through four were all overseeing some aspect of resident care for the fifth floor. The Memory Care Director was also to oversee behaviors. During an interview on 1/27/26 at 2:20 p.m., the Memory Care Director indicated she was not aware of the incident on 12/11/25 when Resident B was observed yelling and hovering over Resident C in their room. She indicated staff were to let her know of any type of behavior any of the residents displayed. During an interview on 1/28/26 at 6:13 a.m., LPN 2 indicated she was the nurse on duty 12/11/25 and was taking care of both residents. The resident yelled all the time, so that was nothing new, however, she did not report that Resident B was observed hovering over Resident C's bed and yelling at him to anyone. At that time, there was no 5th floor unit manager. During an interview on 1/28/26 at 7:18 a.m., RN 1 indicated she was primarily the full time day shift nurse on the fifth floor (memory care unit). She was unaware of the incident that took place on 12/11/25 between Resident B and Resident C. There was supposed to be an end of shift report given to the oncoming nurse so if there were any new or worsening behaviors a resident had exhibited, it should have been passed down to the next shift so they would be able to monitor them. During an interview on 1/28/26 at 11:30 a.m., Nurse Consultant 1 indicated a behavior management meeting was held monthly with the NP from the contracted behavioral center, the pharmacist, the Memory Care Director, some of the nurse managers and the Director of Nursing. They primarily discuss GDR (gradual dose reduction) actions for residents and would review behaviors. She was unsure if the resident was reviewed after the 12/2025 incidents. The current 12/31/24 Behavior Management policy, provided by the Assistant Administrator on 1/27/26 at 9:00 a.m., indicated when a resident exhibited behaviors, it was the responsibility of the staff member that witnessed the behavior to report it to the resident's care staff and document the behavior accordingly. If the behavior was disruptive to others, the resident should be temporally separated from others.The past noncompliance immediate jeopardy began on 12/11/25. The immediate jeopardy was removed and the deficient practice corrected by 12/29/25 after the facility implemented a systemic plan that included the following actions: The facility immediately put a plan of correction into place and had a quality assurance meeting with the department heads. All staff were then inserviced on the different types of abuse and reporting abuse. Staff were also inserviced on the behavior management program for any resident with new or worsening behaviors and when and who to report those behaviors. This citation relates to Intakes 2698383, 2704995, 2705043, 2710478.3.1-28(c)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate treatment and care according to orders, resident's preferences and goals. Based on record review and interview, the facility failed to ensure skin tears were assessed and monitored and treatments were completed as ordered for 1 of 3 residents reviewed for non-pressure related skin conditions, interventions were in place for a resident with hypoglycemia (low blood sugar) for 1 of 1 resident reviewed for hospitalization, and medications were held without parameters for 2 of 5 residents reviewed for unnecessary medications. (Residents D, Y, X, and V)Findings include: 1.The closed record for Resident D was reviewed on 1/22/26 at 8:57 a.m. Diagnoses included, but were not limited to, dementia with behavior disturbance, stroke, and allergic contact dermatitis. The Quarterly Minimum Data Set (MDS) assessment, dated 11/27/25, indicated the resident was moderately impaired for daily decision making and she required partial to moderate assistance from staff for rolling left to right and for bed to chair transfers. A Care Plan, dated 3/20/24 and reviewed on 11/28/25, indicated the resident had an ADL (activities of daily living) self-care performance deficit related to the diagnosis of dementia and history of stroke with low back pain. Interventions included, but were not limited to, the resident required extensive assist by staff to turn and reposition in bed and to move between surfaces. A Physician's Order, dated 7/29/25 and listed as current on the December 2025 Physician's Order Summary (POS), indicated the resident was to wear geri-sleeves (protective skin covering) to the bilateral legs and arms when not wearing long pants or socks. May remove for hygiene. Ensure that resident is wearing sleeves and/or long pants or long socks every shift for skin tears. An Incident Note, dated 12/14/25 at 9:30 p.m., indicated the resident was being pushed in her wheelchair in her room to her bed by staff after being toileted. The writer had witnessed the resident hit her arm against the bed rail while being transported to her bed by the resident's assigned CNA, causing and sustaining two skin tears to the resident's right posterior upper and lower arm, along with a small abrasion to the resident's right ring finger. Orders were received to dress the wound and to monitor until healed. A Physician's Order, dated 12/14/25, indicated the resident's right upper and right lower posterior arm skin tears were to be cleansed with normal saline, pat dry, apply Xeroform (a type of non-adhering gauze dressing), dry gauze, and then wrap with kerlix daily until healed. A Wound Care Note, dated 12/15/25 at 1:28 a.m. and 2:20 p.m., indicated the resident had a new skin condition noted, there had been no reports of signs or symptoms of further injury or infection, no change in mental status or cognition, no reported change in ADL ability or mobility, and no change in orders related to the event. There was no documentation related to the skin tears in the Wound Round section of the resident's record. The December 2025 Treatment Administration Record (TAR) indicated the treatment to the resident's right arm was signed out as 9 (see nurse's notes) on 12/15 and 12/16/25. An Administration Note completed on 12/15/25 at 2:05 p.m., indicated the resident was being followed by wound care to complete the treatment to the right upper and lower arm. The same documentation (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	was completed on 12/16/25 at 3:55 p.m. During an interview on 1/28/26 at 3:32 p.m., the Director of Nursing (DON) indicated the nurse coded a 9 on 12/15 and 12/16/25 because she did not complete the treatment due to the Wound Nurse was supposed to complete the treatment and she thought she had to document something on the TAR. The DON also indicated an assessment of the skin tears should have been completed and documented by Wound Care. The facility policy titled Skin Condition Assessment and Monitoring Pressure and Non-Pressure was provided by the DON on 1/28/26 at 3:54 p.m. The policy indicated, A wound assessment will be initiated and documented in the resident chart when pressure and/or other non-pressure skin conditions are identified by licensed nurse. 3. Resident Y's record was reviewed on 1/23/26 at 2:10 p.m. Diagnoses included, but were not limited to, diabetes mellitus and congestive heart failure. The admission Minimum Data Set assessment, dated 12/20/25, indicated the resident was cognitively intact and received hypoglycemics (medications used to lower blood sugar). An Alert Note, dated 12/20/25, indicated the resident was found to be clammy and not his normal self. Oxygen was applied and blood sugar level was obtained. Blood sugar was found to be low at 47 milligrams/deciliter (mg/dl). 911 was called and resident was transferred to the hospital. There was no indication in the record the physician had been notified, or interventions had been attempted prior to transfer. An Alert Note, dated 12/20/25, indicated the resident had been admitted to the hospital with diagnosis of hypoglycemia. During an interview on 1/27/26 at 12:05 p.m., the Director of Nursing (DON) indicated a resident with hypoglycemia should be assessed, blood sugar obtained, then attempt to give carbohydrates or administer emergency glucagon (glucose). The policy Hypoglycemia Protocol, dated 4/5/25, was received from the DON and indicated, .Give some form of glucose if resident is conscious .Contact physician if blood sugar is below 60 unless there are specific call parameters .If the resident is unable to swallow not fully conscious: Notify physician and prepare glucagon from the emergency drug kit for administration . 3. During observation of a medication pass on 1/22/26 at 9:37 a.m., LPN 6 checked Resident X's blood pressure, and indicated it was 153/58. At 9:53 a.m., LPN 6 administered one tablet of each of the following medications to Resident X: allopurinol (for gout), anastrozole (for breast cancer), atorvastatin (for cholesterol), escitalopram (for depression or anxiety), folic acid (a supplement), montelukast (for asthma), linagliptin (for diabetes), and vitamin D3. No metoprolol tartrate (a medication that reduces the workload of the heart and lowers blood pressure) or amlodipine besylate (a medication that improves blood flow through the heart and lowers blood pressure) were administered. The resident's record was reviewed on 1/22/26 at 2:20 p.m. Diagnoses included, but were not limited to, chronic respiratory failure, diabetes, breast cancer, blindness, and congestive heart failure. The Quarterly Minimum Data Set (MDS) assessment, dated 12/19/25, indicated the resident was (continued on next page)

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 01/28/2026
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)
F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	cognitively intact for daily decision making, required substantial assistance with activities of daily living (ADLs), and had severely impaired vision. The January 2026 Medication Administration Record (MAR) indicated the resident was to receive metoprolol tartrate, 50 mg (milligrams) by mouth twice daily at 9:00 a.m. and 5:00 p.m., and amlodipine besylate, 10 mg every day at 9:00 a.m. There were no blood pressure parameter orders for holding either of the two medications. During an interview on 1/22/26 at 1:50 p.m., LPN 6 indicated she did not give the resident her metoprolol or amlodipine because the resident's diastolic blood pressure (bottom number of blood pressure reading) was below 60 and she did not want the resident to pass out. She indicated there were no ordered blood pressure parameters for holding either medication. During an interview on 1/27/26 at 12:50 p.m., the DON indicated a physician's order was required to hold a medication. 4. The record for Resident V was reviewed on 1/23/26 at 10:36 a.m. Diagnoses included, but were not limited to, hemiplegia (paralysis on one side of the body) following a stroke, diabetes, and adult failure to thrive. The 12/10/25 Quarterly Minimum Data Set (MDS) indicated the resident was cognitively intact for daily decision making and was dependent in activities of daily living (ADLs) and transfers. The January 2026 Medication Administration Record (MAR) indicated the following: a. Lantus insulin, 15 units each morning, to be given daily at 6:00 a.m. The documentation box was blank on 1/16, 1/17, 1/20, and 1/21. There were no notes or orders related to the blanks. b. Entresto (a medication used to reduce the risk of cardiovascular death), 1 tab twice a day. The 5:00 p.m. dose was held on 1/1, 1/4, 1/13, 1/17, and 1/18. There were no parameters or orders for holding the medication. c. Metoprolol 12.5 mg twice a day. The 5:00 p.m. dose was held on 1/1, 1/3, 1/4, 1/12, 1/13, 1/15, 1/17, 1/18, and 1/20. The 9:00 a.m. dose was held on 1/22/26. There were no parameters or orders for holding the medication. d. Humalog (a rapid-acting insulin) sliding scale (dosed according to blood sugar level) daily at 6:00 a.m., 11:00 a.m., and 4:00 p.m. The 6:00 a.m. blood sugar and administration documentation boxes were blank on 1/16, 1/17, 1/20, and 1/21. There were no notes or orders related to the blanks. A Care Plan, revised on 6/30/25, indicated the resident required daily insulin therapy related to a diagnosis of diabetes. Interventions included administering insulin as ordered. A Care Plan, revised on 6/30/25, indicated the resident had the potential for complications related to ischemic cardiomyopathy (heart disease that leads to heart failure). Interventions included to give medications as ordered. During an interview on 1/27/26 at 3:50 p.m., the DON was informed of the findings and offered no further information. (continued on next page)

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 01/28/2026

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

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	This citation relates to Intakes 2698383 and 2699928. 3.1-37(a)

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 01/28/2026

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(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. Based on observation, record review and interview, the facility failed to ensure interventions were in place and the correct treatment was provided for 2 of 4 residents reviewed for pressure ulcers. (Residents T and U)Findings Include:1.On 1/27/26 at 10:15 a.m., Resident T's wound care was observed with the Wound Nurse. The resident was positioned on his left side in his bed. There was a small pressure ulcer, approximately 0.5 centimeter long on his sacrum. The nurse cleansed the area with normal saline and gauze, patted it dry, then applied a hydrocolloid dressing to cover the wound.The resident's record was reviewed on 1/22/26 at 9:40 a.m. Diagnoses included, but were not limited to, fracture of the left humerus and cellulitis of the left lower extremity.The admission Minimum Data Set (MDS) assessment, dated 12/1/25, indicated the resident had moderate cognitive impairment and needed partial/moderate assist with bed mobility and transfers. A Physician's Order, dated 12/19/25, indicated to cleanse the sacrum with normal saline and/ or wound cleanser, apply skin prep to the surrounding skin and cover with a hydrocolloid.During an interview with the Wound Nurse following the wound care, she indicated she did not apply the skin prep as ordered. 2. On 1/22/26 at 10:38 a.m. and 1/23/26 at 8:45 a.m., Resident U was observed in bed. There was a standard mattress on the bed with a padded overlay. The resident's feet were on the mattress, there was no pillow present for offloading his heels or padded boots in place. The resident's record was reviewed on 1/22/26 at 2:55 p.m. Diagnoses included, but was not limited to, multiple sclerosis, cerebral infarction and peripheral vascular disease. The resident had a pressure ulcer to his sacrum /buttocks.The Quarterly Minimum Data Set assessment, dated 12/22/25, indicated the resident was cognitively intact, had range of motion impairment to both sides and was dependent for toileting and transfers.A Physician's Order, dated 5/10/23, indicated to suspend or offload heels while in bed. During an interview on 1/23/26 at 8:47 a.m., the Unit 2 Manager was made aware the resident's heels were not offloaded. She indicated he did not like to wear the boots, but there should be a pillow for offloading. This citation relates to Intake 2702705.3.1-40(a)(2)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. Based on record review and interview, the facility failed to ensure a scheduled pain medication was available and administered as ordered for 1 of 4 residents reviewed for pressure ulcers. (Resident F)Finding includes:Resident F's closed record was reviewed on 1/21/26 at 2:15 p.m. Diagnoses included, but were not limited to, diabetes mellitus, repeated falls, and unspecified protein calorie malnutrition.The Quarterly Minimum Data Set assessment, dated 11/17/25, indicated the resident was cognitively intact and had a stage 3 (full-thickness skin injury appearing as a deep crater where subcutaneous fat is visible, but muscle, tendon, or bone are not exposed) pressure ulcer.The Pain Care Plan, dated 6/19/23, indicated the resident was on pain medication related to cancer of left breast, chronic pain syndrome and arthritis. Interventions included, but were not limited to, administer analgesic medications as ordered.A Physician's Order, dated 4/9/24, indicated to give fentanyl transdermal patch (opioid pain medication), 50 micrograms/hour every 72 hours for pain.The November and December 2025 Medication Administration Record indicated the fentanyl patch was not administered on 11/21, 11/24, 11/27, 11/30, 12/3 and 12/6/25. Order Administration (OA) Notes indicated the following:11/21/25 - the medication was not available. 11/24/25 - message sent to the doctor to refill script.11/27/25 - unavailable, prescription needed, MD notified.12/3/25 - unavailable.12/6/25 - no script. During an interview on 1/22/26 at 3:15 p.m., the Director of Nursing indicated the Nurse Practitioner should have been notified and a script obtained. She later indicated they had received a new prescription for the fentanyl patch on 11/25/25, but the pharmacy didn't receive it. The Medication Orders policy was received but did not pertain to the above. This citation relates to Intake 2702705.3.1-37(a)