STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155131	A. BUILDING -- B. WING	08/30/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MUNSTER MED-INN	7935 CALUMET AVE MUNSTER, IN 46321

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 0000 Bldg. --	An Emergency Preparedness Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.73. Survey Date: 08/30/21 Facility Number: 000056 Provider Number: 155131 AIM Number: 100289450 At this Emergency Preparedness survey, Munster Med-Inn, was found in compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 483.73 The facility has 225 certified beds. At the time of the survey, the census was 180. Quality Review completed on 09/02/21	E 0000		
K 0000 Bldg. 03	A Life Safety Code Recertification and State Licensure Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.90(a). Survey Date: 08/30/21 Facility Number: 000056 Provider Number: 155131 AIM Number: 100289450 At this Life Safety Code survey, Munster Med-Inn was found not in compliance with	K 0000	Please accept the evidence submitted for approval and a desk review	

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

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds 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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	155131	A. BUILDING 03 B. WING	08/30/2021

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	Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.90(a), Life Safety from Fire and the 2012 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19, Existing Health Care Occupancies and 410 IAC 16.2. This six-story facility with a full basement was determined to be of Type I (332) construction and was fully sprinklered. The facility has a fire alarm system with hard wired smoke detection in the corridors and spaces open to the corridors. Battery operated smoke detectors are installed in all resident rooms. The building is fully protected by a 200-kW diesel-powered generator. The facility has the capacity for 225 and had a census of 180 at the time of this survey. All areas where the residents have customary access were sprinklered and all areas providing facility services were sprinklered. Quality Review completed on 09/02/21			
K 0211 SS=E Bldg. 03	NFPA 101 Means of Egress - General Means of Egress - General Aisles, passageways, corridors, exit discharges, exit locations, and accesses are in accordance with Chapter 7, and the means of egress is continuously maintained free of all obstructions to full use in case of emergency, unless modified by 18/19.2.2 through 18/19.2.11. 18.2.1, 19.2.1, 7.1.10.1 Based on observation and interview, the facility failed to maintain 1 of 2 first floor exits in accordance with LSC 19.2.1. Section 19.2.1	K 0211	**Munster Med Inn Life Safety Code Recertification and State Licensure Survey:**	09/03/2021

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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	states Every aisle, passageway, corridor, exit discharge, exit location, and access shall be in accordance with Chapter 7, unless otherwise modified by 19.2.2 through 19.2.11. Chapter 7, Section 7.1.10.1 states that means of egress shall be continuously maintained free of all obstructions or impediments to full instant use in the case of fire or other emergency. This deficient practice could affect residents and staff on the odd wing of the fourth floor. Based on an observation on 8/30/21 with the Maintenance Director and Corporate Facilities Engineer at 12:15 p.m., there was a chair and a bedside serving table stored in the corridor outside resident room 417. Based on an interview at the time of observation, the Maintenance Director acknowleged the chair and table in the corridor and stated nursing staff sometimes pull a chair from a resident room to the corridor and sit when they chart. During the exit conference with the facility Maintenance Director and the Property Manager at 1:56 p.m., no additional information or evidence could be provided contrary to this deficient finding. 3.1-19(b)		**8-30-2021** K (211) Please accept the following as the facility's plan of correction. This plan of correction does not constitute an admission of guilt or liability by the facility and is submitted only in response to the regulatory requirement. **What corrective action will be accomplished for those residents found to have been affected by the deficient practice?** *The improper storage of chair and table in 4th floor corridor outside 417 was immediately removed during survey.* **How will the facility identify other residents having the potential to be affected by the same deficient practice?** *The deficient practice has the potential to affect all staff, residents, and visitors on the 4th floor in the event of an emergency evacuation.* **What measures will the facility take or what systems will the facility alter to ensure that the problem will be corrected and will not recur?** *All staff was educated on not storing anything in the corridors. A random weekly audit will be performed for 3 months of all corridors.*	

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			How will the corrective action be monitored to ensure the deficient practice will not recur and what quality assurance program will be put into place? *Copy of audit will be reviewed at safety committee meeting for a duration of 3 months. All other deficient practices will be immediately corrected upon occurrence.* **Date of Completion: 9/3/2021**	
K 0225 SS=E Bldg. 03	NFPA 101 Stairways and Smokeproof Enclosures Stairways and Smokeproof Enclosures Stairways and Smokeproof enclosures used as exits are in accordance with 7.2. 18.2.2.3, 18.2.2.4, 19.2.2.3, 19.2.2.4, 7.2 Based on observation and interview, the facility failed to ensure items stored in 1 of 3 fire escape stairways would not interfere with egress. LSC 7.2.2.5.1 states Open space within the exit enclosure shall not be used for any purpose that has the potential to interfere with egress. This deficient practice could affect as many as 25 residents, 5 staff, and 2 visitors using Stairwell #3 in the event of an emergency. Findings include: Based on observation made on 08/30/21 at 11:41 a.m., during a tour of the facility with the Maintenance Director and the Property Manager, the #3 stairwell at the basement level had six one-gallon paint cans stored underneath the	K 0225	**Munster Med Inn** **Life Safety Code Recertification and State Licensure Survey: 8-30-2021** K (225) Please accept the following as the facility's plan of correction. This plan of correction does not constitute an admission of guilt or liability by the facility and is submitted only in response to the regulatory requirement. **What corrective action will be accomplished for those residents found to have been affected by the deficient**	09/03/2021

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	155131	A. BUILDING 03 B. WING	08/30/2021

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	stairwell. Based on interview at the time of observation, the Maintenance Director acknowledged the aforementioned stairwell area as being used for storage, and immediately removed the six gallons of paint to the paint storage room approximately 25 feet from the stairwell. This deficiency was removed prior to my completion of the survey and the exiting of the facility. 3.1-19(b)		**practice?** *The Facility immediately removed the 6 gallons of paint from stairway 3 during the survey.* **How will the facility identify other residents having the potential to be affected by the same deficient practice?** *The deficient practice has the potential to affect all staff, residents, and visitors in the event of the paint cans causing a fire in the stairway 3.* **What measures will the facility take or what systems will the facility alter to ensure that the problem will be corrected and will not recur?** *Maintenance department was educated on not storing anything in the stairways. A weekly audit will be performed for 3 months of all stairways to ensure compliance.* How will the corrective action be monitored to ensure the deficient practice will not recur and what quality assurance program will be put into place? *Copy of audit will be reviewed at safety committee meeting for a duration of 3 months. All other deficient practices will be immediately corrected upon occurrence.*	

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			Date of Completion: 9/3/2021	
K 0321 SS=E Bldg. 03	NFPA 101 Hazardous Areas - Enclosure Hazardous Areas - Enclosure Hazardous areas are protected by a fire barrier having 1-hour fire resistance rating (with 3/4 hour fire rated doors) or an automatic fire extinguishing system in accordance with 8.7.1 or 19.3.5.9. When the approved automatic fire extinguishing system option is used, the areas shall be separated from other spaces by smoke resisting partitions and doors in accordance with 8.4. Doors shall be self-closing or automatic-closing and permitted to have nonrated or field-applied protective plates that do not exceed 48 inches from the bottom of the door. Describe the floor and zone locations of hazardous areas that are deficient in REMARKS. 19.3.2.1, 19.3.5.9 Area Automatic Sprinkler Separation N/A a. Boiler and Fuel-Fired Heater Rooms b. Laundries (larger than 100 square feet) c. Repair, Maintenance, and Paint Shops d. Soiled Linen Rooms (exceeding 64 gallons) e. Trash Collection Rooms (exceeding 64 gallons) f. Combustible Storage Rooms/Spaces (over 50 square feet) g. Laboratories (if classified as Severe Hazard - see K322) Based on observation and interview, the facility	K 0321	**Munster Med Inn**	09/03/2021

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	failed to ensure the corridor door to 2 of 16 hazardous areas, such as combustible storage rooms over 50 square feet, soiled linen rooms, and boiler rooms, were provided with self-closing devices which would cause the doors to automatically close and latch into the door frames or provided with smoke resistant partitions. This deficient practice could affect as many as 30 residents, 10 employees and 4 visitors on the ground floor. Findings include: Based on observations made with the Maintenance Director and the Property Manager on 08/30/21 during a tour of the facility between 11:20 a.m. to 2:45 p.m., the following was noted: 1) the Town Chapel room on the ground floor was being used for facility storage and was approximately 250 square feet in size. There were numerous cardboard boxes, 50-gallon tubs, and plastic boxes of Christmas decorations throughout the room. Most of this storage was combustible and therefore created a hazardous area. The corridor door to this room did not have a self-closing device attached to it. 2) the Men's Barber Shop on the ground floor was being used for facility storage and was approximately 200 square feet in size. It contained approximately 25 - 24-inch-long by 18-inch-wide by 24-inch-high miscellaneous boxes of medical supplies creating a hazardous area. The corridor door to this room did not have a self-closing device attached to it. Based on an interview at the time of each observation, the Maintenance Director stated that he had no idea that staff was getting ready for the Christmas Holiday so soon, and that they were using these aforementioned areas as storage rooms to get the decorations ready to display for		**Life Safety Code Recertification and State Licensure Survey: 8-30-2021** K (321) Please accept the following as the facility's plan of correction. This plan of correction does not constitute an admission of guilt or liability by the facility and is submitted only in response to the regulatory requirement. **What corrective action will be accomplished for those residents found to have been affected by the deficient practice?** *The Facility installed a self-closing device on 1) Town Chapel and 2) Men's Barber Shop door.* **How will the facility identify other residents having the potential to be affected by the same deficient practice?** *The deficient practice has the potential to affect all staff, residents, and visitors on the ground floor if doors did not close and combustibles caught fire.* **What measures will the facility take or what systems will the facility alter to ensure that the problem will be corrected and will not recur?** *Maintenance department was educated on combustible storage room doors*	

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	155131	A. BUILDING 03 B. WING	08/30/2021

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	the upcoming holiday. During the exit conference with the facility Maintenance Director and the Property Manager at 1:56 p.m., no additional information or evidence could be provided contrary to this deficient finding. 3.1-19(b)		*needing self-closing device. A onetime audit of all combustible storage rooms to ensure compliance.* How will the corrective action be monitored to ensure the deficient practice will not recur and what quality assurance program will be put into place? *Copy of audit will be reviewed at safety committee meeting for a duration of 3 months. All other deficient practices will be immediately corrected upon occurrence.* **Date of Completion: 9/3/2021**	
K 0351 SS=E Bldg. 03	NFPA 101 Sprinkler System - Installation Spinkler System - Installation 2012 EXISTING Nursing homes, and hospitals where required by construction type, are protected throughout by an approved automatic sprinkler system in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems. In Type I and II construction, alternative protection measures are permitted to be substituted for sprinkler protection in specific areas where state or local regulations prohibit sprinklers. In hospitals, sprinklers are not required in clothes closets of patient sleeping rooms where the area of the closet does not exceed 6 square feet and sprinkler coverage covers			

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	the closet footprint as required by NFPA 13, Standard for Installation of Sprinkler Systems. 19.3.5.1, 19.3.5.2, 19.3.5.3, 19.3.5.4, 19.3.5.5, 19.4.2, 19.3.5.10, 9.7, 9.7.1.1(1)			
	Based on observation and interview, the facility failed to ensure the spray pattern for 3 of over 1000 sprinkler heads were not obstructed in accordance with 19.3.5.1. NFPA 13, 2010 edition, Section 8.5.5.1 states sprinklers shall be located so as to minimize obstructions to discharge as defined in 8.5.5.2 and 8.5.5.3 or additional sprinklers shall be provided to ensure adequate coverage of the hazard. Sections 8.5.5.2 and 8.5.5.3 do not permit continuous or noncontinuous obstructions less than or equal to 18 inches below the sprinkler deflector or in a horizontal plane more than 18 inches below the sprinkler deflector that prevent the spray pattern from fully developing. This deficient practice could affect as many as 6 staff only. Findings include: Based on observations made with the Maintenance Director and the Property Manager on 08/30/21 during a tour of the facility between 11:20 a.m. to 2:45 p.m., the following was noted: 1) the walk-in freezer located in the basement contained numerous boxes of frozen food stacked up on shelves. Several of the boxes were stacked so high as to come within seven inches from the deflector on the sprinkler head. 2) the sprinkler head located in the Maintenance Directors office was approximately eight inches from the fan blade of the ceiling fan located directly above the Maintenance Directors desk. Based on interview at the time of each aforementioned observation, the Maintenance Director acknowledged the aforementioned	K 0351	**Munster Med Inn** **Life Safety Code Recertification and State Licensure Survey: 8-30-2021** K (351) Please accept the following as the facility's plan of correction. This plan of correction does not constitute an admission of guilt or liability by the facility and is submitted only in response to the regulatory requirement. **What corrective action will be accomplished for those residents found to have been affected by the deficient practice?** *1) The Facility adjusted boxes in basement freezer to be below 18" rule.* *2) The ceiling fan in the maintenance director office was removed. 3a) The Facility replaced damaged ceiling tile by vent above 2nd floor nurse station. 3b) The Facility replaced the ceiling tiles that had gaps around sprinkler heads in the lounge.* **How will the facility identify other residents having the potential to be affected by the same deficient practice?** *1) The deficient practice has the*	09/03/2021

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	condition, and confirmed the listed measurements. During the exit conference with the facility Maintenance Director and the Property Manager at 1:56 p.m., no additional information or evidence could be provided contrary to this deficient finding. 3.1-19(b) 2) Based on observation and interview, the facility failed to maintain the ceiling construction in 1 of 1 second floor nurse station and lounge. NFPA 13, 2010 edition, Section 3.3.5.4 defines a smooth ceiling as a continuous ceiling free from significant irregularities, lumps, or indentations. The ceiling traps hot air and gases around the sprinkler and cause the sprinkler to operate at a specified temperature. Section 8.5.4.1.1 states the distance between the sprinkler deflector and the ceiling above shall be selected based on the type of sprinkler and the type of construction. This deficient practice could affect 30 residents and staff in the vicinity of the second-floor nurses station and second floor lounge. Findings include: Based on observations with the Maintenance Director and Corporate Facilities Engineer during a tour of the facility from 11:20 a.m. to 1:25 p.m. on 08/30/21, the following was noted: a. there was a one inch by five-inch opening in the lay in ceiling tile by the vent above the second-floor nurses station exposing the ceiling above. b. there were one half inch half-moon shape opening around 4 sprinkler heads in the second-floor lounge exposing the ceiling above. Based on interview at the time of the		*potential to affect all staff located in the basement in the event of a fire in the freezer and the sprinkler was obstructed. 2) The deficient practice has the potential to affect all staff in the basement in the event of a fire in maintenance director office and sprinkler was obstructed. 3a,3b) The deficient practice has the potential to affect all staff, residents, and visitors of 2nd floor smoke compartment in the event of a fire and ceiling was not smoke tight.* **What measures will the facility take or what systems will the facility alter to ensure that the problem will be corrected and will not recur?** *1) Kitchen staff was educated on 18" rule. A weekly audit of kitchen freezer and cooler will be conducted for 3 months to ensure compliance. 2) Maintenance was educated on 18" rule in offices. A onetime audit of all offices to ensure compliance 3a, 3b) Maintenance department was educated on maintaining proper ceiling assembly. A random audit will be performed weekly for 3 months of all ceiling tiles to ensure compliance.* How will the corrective action be	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155131	A. BUILDING 03 B. WING	08/30/2021

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	observations, the Maintenance Director acknowledged the ceiling conditions in the aforementioned locations. During the exit conference with the facility Maintenance Director and the Property Manager at 1:56 p.m., no additional information or evidence could be provided contrary to this deficient finding. 3.1-19(b)		monitored to ensure the deficient practice will not recur and what quality assurance program will be put into place? *Copy of audits will be reviewed at safety committee meeting for a duration of 3 months. All other deficient practices will be immediately corrected upon occurrence.* **Date of Completion: 9/3/2021**	
K 0353 SS=F Bldg. 03	NFPA 101 Sprinkler System - Maintenance and Testing Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked _____________________ b) Who provided system test ____________________________ c) Water system supply source __________________________ Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25			
	Based on record review and interview, the facility failed to ensure the sprinkler system was maintained in accordance with NFPA 25. LSC 9.7.5 requires all sprinkler systems shall be inspected, tested, and maintained in accordance	K 0353	**Munster Med Inn** **Life Safety Code Recertification and State Licensure Survey: 8-30-2021** K (353)	09/03/2021

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	with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. NFPA 25, 2011 Edition, Section 10.2.9 states Chapter 8 shall be followed for inspection and maintenance requirements for fire pumps. Section 8.2.2 states pertinent visual observations shall be performed weekly. Section 8.3.1.2 states electric motor-driven fire pumps shall be operated monthly. Section 4.1.4.1 states the property owner or designated representative shall correct or repair deficiencies or impairments that are found during the inspection, test, and maintenance required by this standard. Section 4.3.1 states records shall be made for all inspections, tests, and maintenance of the system and its components and shall be made available to the authority having jurisdiction upon request. This deficient practice could affect all residents, staff, and visitors. Findings include: Based on record review with the Maintenance Director and the Property Manager on 08/30/21 between 9:20 a.m. and 11:21 a.m. it was noted that the facility had an electric fire pump. The most recent documentation of a fire pump inspection was more than 12 months old and was dated May of 2020. Based on an interview at the time of record review, the Maintenance Director explained that the breaker to the fire pump had malfunctioned and had to be replaced. That repair was just recently completed, and the documentation of the repair was provided for inspection. An e-mail provided from the facility vendor stated that the annual fire pump test was now scheduled to be completed on 08/31/21. Based on further interview at the time of record review, the Maintenance Director acknowledged that the facility fire pump had not been inspected		Please accept the following as the facility's plan of correction. This plan of correction does not constitute an admission of guilt or liability by the facility and is submitted only in response to the regulatory requirement. **What corrective action will be accomplished for those residents found to have been affected by the deficient practice?** *The Fire pump annual test was completed on 8-31-2021 by Fire Alarm Company.* **How will the facility identify other residents having the potential to be affected by the same deficient practice?** *The deficient practice has the potential to affect all staff, residents, and visitors in the event of a fire and the fire pump failed.* **What measures will the facility take or what systems will the facility alter to ensure that the problem will be corrected and will not recur?** *Maintenance was educated on annual testing of Fire Pump.* How will the corrective action be monitored to ensure the deficient practice will not recur and what quality assurance program will be	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155131	A. BUILDING 03 B. WING	08/30/2021

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	within the last 12-month period. During the exit conference with the facility Maintenance Director and the Property Manager at 1:56 p.m., no additional information or evidence could be provided contrary to this deficient finding. 3.1-19(b)		put into place? *A copy of repair work order will be reviewed at safety committee meeting to ensure compliance.* **Date of Completion: 9/3/2021**	
K 0374 SS=E Bldg. 03	NFPA 101 Subdivision of Building Spaces - Smoke Barrie Subdivision of Building Spaces - Smoke Barrier Doors 2012 EXISTING Doors in smoke barriers are 1-3/4-inch thick solid bonded wood-core doors or of construction that resists fire for 20 minutes. Nonrated protective plates of unlimited height are permitted. Doors are permitted to have fixed fire window assemblies per 8.5. Doors are self-closing or automatic-closing, do not require latching, and are not required to swing in the direction of egress travel. Door opening provides a minimum clear width of 32 inches for swinging or horizontal doors. 19.3.7.6, 19.3.7.8, 19.3.7.9			
	Based on observation and interview, the facility failed to ensure 1 of 3 sets of smoke barrier doors on the ground floor would restrict the movement of smoke for at least 20 minutes. LSC 19.3.7.8 requires doors in smoke barriers shall comply with LSC Section 8.5.4. LSC 8.5.4.1 requires doors in smoke barrier shall close the opening leaving only the minimum clearance necessary for proper operation. This deficient practice could affect as many as 30 residents, 10 employees and 4 visitors exiting the facility by the ground floor. Findings include:	K 0374	**Munster Med Inn** **Life Safety Code Recertification and State Licensure Survey: 8-30-2021** K (374) Please accept the following as the facility's plan of correction. This plan of correction does not constitute an admission of guilt or liability by the facility and is submitted only in response to the regulatory requirement. **What corrective action will be**	09/08/2021

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155131	A. BUILDING 03 B. WING	08/30/2021

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	Based on observations made on 08/30/21 at 12:50 p.m. during a tour of the facility with the Maintenance Director and the Property Manager, the set of smoke barrier doors nearest to the main entrance to the facility did not close completely when tested three separate times. There was a three-inch gap between the doors when closed to their fullest. Based on interview during the time of observations, the Maintenance Director acknowledged these smoke barrier doors did not close completely and confirmed the above listed gap measurement. During the exit conference with the facility Maintenance Director and the Property Manager at 1:56 p.m., no additional information or evidence could be provided contrary to this deficient finding. 3.1-19(b)		**accomplished for those residents found to have been affected by the deficient practice?** *The Coordinator on fire/smoke doors hallway by front reception was adjusted and tested. Doors are now closing and latching properly.* **How will the facility identify other residents having the potential to be affected by the same deficient practice?** *The deficient practice has the potential to affect all staff, residents, and visitors on the ground floor if doors did not close and latch during a fire.* **What measures will the facility take or what systems will the facility alter to ensure that the problem will be corrected and will not recur?** *Maintenance department was educated on use of coordinators on fire and smoke doors and need for doors to close and latch properly. A weekly random audit of all fire/smoke doors with coordinators for 3 months will be conducted to ensure compliance.* How will the corrective action be monitored to ensure the deficient practice will not recur and what quality assurance program will be put into place? *Copy of audit will*	

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			be reviewed at safety committee meeting for a duration of 3 months. All other deficient practices will be immediately corrected upon occurrence. **Date of Completion: 9/8/2021**	
K 0511 SS=E Bldg. 03	NFPA 101 Utilities - Gas and Electric Utilities - Gas and Electric Equipment using gas or related gas piping complies with NFPA 54, National Fuel Gas Code, electrical wiring and equipment complies with NFPA 70, National Electric Code. Existing installations can continue in service provided no hazard to life. 18.5.1.1, 19.5.1.1, 9.1.1, 9.1.2 Based on observation and interview, the facility failed to ensure 1 of over 10 wet locations, were provided with ground fault circuit interrupter (GFCI) protection against electric shock. NFPA 70, NEC 2011 Edition at 210.8 Ground-Fault Circuit-Interrupter Protection for Personnel, states, ground-fault circuit-interruption for personnel shall be provided as required in 210.8(A) through (C). The ground-fault circuit-interrupter shall be installed in a readily accessible location. Informational Note: See 215.9 for ground-fault circuit interrupter protection for personnel on feeders. (B) Other Than Dwelling Units. All 125-volt, single-phase, 15- and 20-ampere receptacles installed in the locations specified in 210.8(B) (1) through (8) shall have ground-fault circuit-interrupter protection for personnel. (1) Bathrooms	K 0511	**Munster Med Inn** **Life Safety Code Recertification and State Licensure Survey: 8-30-2021** K (511) Please accept the following as the facility's plan of correction. This plan of correction does not constitute an admission of guilt or liability by the facility and is submitted only in response to the regulatory requirement. **What corrective action will be accomplished for those residents found to have been affected by the deficient practice?** *The GFCI on 1st floor in soiled utility was replaced and tested and now operating*	09/03/2021

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	155131	A. BUILDING 03 B. WING	08/30/2021

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	(2) Kitchens (3) Rooftops (4) Outdoors Exception No. 1 to (3) and (4): Receptacles that are not readily accessible and are supplied by a branch circuit dedicated to electric snow-melting, deicing, or pipeline and vessel heating equipment shall be permitted to be installed in accordance with 426.28 or 427.22, as applicable. Exception No. 2 to (4): In industrial establishments only, where the conditions of maintenance and supervision ensure that only qualified personnel are involved, an assured equipment grounding conductor program as specified in 590.6(B)(2) shall be permitted for only those receptacle outlets used to supply equipment that would create a greater hazard if power is interrupted or having a design that is not compatible with GFCI protection. (5) Sinks - where receptacles are installed within 1.8 m (6 ft.) of the outside edge of the sink. Exception No. 1 to (5): In industrial laboratories, receptacles used to supply equipment where removal of power would introduce a greater hazard shall be permitted to be installed without GFCI protection. Exception No. 2 to (5): For receptacles located in patient bed locations of general care or critical care areas of health care facilities other than those covered under 210.8(B)(1), GFCI protection shall not be required. (6) Indoor wet locations (7) Locker rooms with associated showering facilities (8) Garages, service bays, and similar areas where electrical diagnostic equipment, electrical hand tools. NFPA 70, 517-20 Wet Locations, requires all		*properly.* **How will the facility identify other residents having the potential to be affected by the same deficient practice?** *The deficient practice has the potential to affect all staff, residents, and visitors on the 1st floor if the device failed and caused a fire.* **What measures will the facility take or what systems will the facility alter to ensure that the problem will be corrected and will not recur?** *Maintenance was educated on operation and testing of GFCI receptacles. A monthly random audit of all GFCI receptacles for 3 months will be conducted to ensure compliance.* How will the corrective action be monitored to ensure the deficient practice will not recur and what quality assurance program will be put into place? *Copy of audit will be reviewed at safety committee meeting for a duration of 3 months. All other deficient practices will be immediately corrected upon occurrence.* **Date of Completion: 9/3/2021**	

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	155131	A. BUILDING 03 B. WING	08/30/2021

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	receptacles and fixed equipment within the area of the wet location to have ground-fault circuit interrupter (GFCI) protection. Note: Moisture can reduce the contact resistance of the body, and electrical insulation is more subject to failure. This deficient practice could affect up to 10 residents and staff in the vicinity of first floor soiled utility. Findings include: Based on observation on 08/30/21 between 11:20 a.m. and 1:25 p.m. during a tour of the facility with the Maintenance Director and Corporate Facilities Engineer, an electric receptacles within three feet of the sink in the first floor soiled utility room was provided with GFCI receptacles, however, when tested with a GFCI testing device the receptacles did not trip. Based on interview at the time of observation, the Maintenance Director acknowledged the GFCI receptacle did not trip when tested and said the receptacle would be replaced as soon as possible. During the exit conference with the facility Maintenance Director and the Property Manager at 1:56 p.m., no additional information or evidence could be provided contrary to this deficient finding. 3.1-19(b)			
K 0920 SS=E Bldg. 03	NFPA 101 Electrical Equipment - Power Cords and Extens Electrical Equipment - Power Cords and Extension Cords Power strips in a patient care vicinity are only used for components of movable patient-care-related electrical equipment (PCREE) assembles that have been			

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	assembled by qualified personnel and meet the conditions of 10.2.3.6. Power strips in the patient care vicinity may not be used for non-PCREE (e.g., personal electronics), except in long-term care resident rooms that do not use PCREE. Power strips for PCREE meet UL 1363A or UL 60601-1. Power strips for non-PCREE in the patient care rooms (outside of vicinity) meet UL 1363. In non-patient care rooms, power strips meet other UL standards. All power strips are used with general precautions. Extension cords are not used as a substitute for fixed wiring of a structure. Extension cords used temporarily are removed immediately upon completion of the purpose for which it was installed and meets the conditions of 10.2.4. 10.2.3.6 (NFPA 99), 10.2.4 (NFPA 99), 400-8 (NFPA 70), 590.3(D) (NFPA 70), TIA 12-5			
	1. Based on observation and interview, the facility failed to ensure 1 of 1 second floor Social Services office did not use flexible cords as a substitute for fixed wiring. LSC 9.1.2 requires electrical wiring and equipment shall be in accordance with NFPA 70, National Electrical Code. NFPA 70, 2011 Edition, Article 400.8 requires that, unless specifically permitted, flexible cords and cables shall not be used as a substitute for fixed wiring of a structure. This deficient practice affects as many as 15 residents and staff in the vicinity of the second floor social services office. Findings include: Based on observation with the Maintenance Director and Corporate Facilities Engineer during a tour of the facility from 11:30 a.m. to 1:25 p.m. on 08/30/21 the following was noted	K 0920	**Munster Med Inn** **Life Safety Code Recertification and State Licensure Survey: 8-30-2021** K (920) Please accept the following as the facility's plan of correction. This plan of correction does not constitute an admission of guilt or liability by the facility and is submitted only in response to the regulatory requirement. **What corrective action will be accomplished for those residents found to have been affected by the deficient practice?** *1a) The refrigerator was plugged directly into wall outlet.*	09/03/2021

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155131	A. BUILDING 03 B. WING	08/30/2021

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	within the Social Services office: a) a refrigerator was plugged into a powerstrip. b) a wax melt warmer was plugged into a power strip. Based on interview at the time of each observation, the Maintenance Director acknowledged the power strip as being in use within the Social Services office as a substitute for fixed wiring and stated that he would remedy the issue as soon as he was able to do so. During the exit conference with the facility Maintenance Director and the Property Manager at 1:56 p.m., no additional information or evidence could be provided contrary to this deficient finding. 3.1-19(b) 2. Based on observation and interview, the facility failed to ensure 1 of 1 extension cords including multi plug adapters were not used as a substitute for fixed wiring. LSC 19.5.1 requires utilities to comply with Section 9.1. LSC 9.1.2 requires electrical wiring and equipment to comply with NFPA 70, National Electrical Code, 2011 Edition. NFPA 70, Article 400.8 requires that, unless specifically permitted, flexible cords and cables shall not be used as a substitute for fixed wiring of a structure. LSC Section 4.5.7 states any building service equipment or safeguard provided for life safety shall be designed, installed and approved in accordance with all applicable NFPA standards. NFPA 99, Standard for Health Care Facilities, 2012 edition, defines patient care areas as any portion of a health care facility wherein patients are intended to be examined or treated. Patient care vicinity is defined as a space, within a location intended for the examination and treatment of patients, extending 6 ft (1.8 m) beyond the		*1b) The wax warmer was removed from social service during survey.* *2) The power strip was immediately removed from room 408* **How will the facility identify other residents having the potential to be affected by the same deficient practice?** *1a, 1b) The deficient practice has the potential to affect all staff, residents, and visitors on the 2nd floor if the deficiencies caused a fire. 2) The deficient practice has the potential to affect all staff, residents, and visitors on the 4th floor if the deficiencies caused a fire* **What measures will the facility take or what systems will the facility alter to ensure that the problem will be corrected and will not recur?** *All staff was educated on electrical safety and proper receptacle usage. A random weekly audit of resident rooms and offices for 3 months will be conducted to ensure compliance.* How will the corrective action be monitored to ensure the deficient practice will not recur and what quality assurance program will be put into place? *Copy of audit will*	

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	normal location of the bed, chair, table, treadmill, or other device that supports the patient during examination and treatment. A patient care vicinity extends vertically to 7 ft 6 in. (2.3 m) above the floor. NFPA 99, Section 10.4.2.3 states household or office appliances not commonly equipped with grounding conductors in their power cords shall be permitted provided they are not located within the patient care vicinity. This deficient practice could affect over 10 residents, staff and visitors in the vicinity of Room 408. Findings include: Based on observations with the Maintenance Director and Corporate Facilities Engineer during a tour of the facility at on 08/30/21 from 11:30 a.m. to 1:25 p.m. the resident bed and a radio were plugged into a multiplug adapter that was plugged into a wall outlet in resident sleeping room 408. Based on interview at the time of the observations, the Maintenance Director agreed the multiplug adapter was being used as a substitute for fixed wiring at the aforementioned location. During the exit conference with the facility Maintenance Director and the Property Manager at 1:56 p.m., no additional information or evidence could be provided contrary to this deficient finding. 3.1-19(b)		*be reviewed at safety committee meeting for a duration of 3 months. All other deficient practices will be immediately corrected upon occurrence.* **Date of Completion: 9/3/2021**	
K 0923 SS=E Bldg. 03	NFPA 101 Gas Equipment - Cylinder and Container Storag Gas Equipment - Cylinder and Container Storage Greater than or equal to 3,000 cubic feet Storage locations are designed, constructed,			

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	and ventilated in accordance with 5.1.3.3.2 and 5.1.3.3.3. >300 but <3,000 cubic feet Storage locations are outdoors in an enclosure or within an enclosed interior space of non- or limited- combustible construction, with door (or gates outdoors) that can be secured. Oxidizing gases are not stored with flammables, and are separated from combustibles by 20 feet (5 feet if sprinklered) or enclosed in a cabinet of noncombustible construction having a minimum 1/2 hr. fire protection rating. Less than or equal to 300 cubic feet In a single smoke compartment, individual cylinders available for immediate use in patient care areas with an aggregate volume of less than or equal to 300 cubic feet are not required to be stored in an enclosure. Cylinders must be handled with precautions as specified in 11.6.2. A precautionary sign readable from 5 feet is on each door or gate of a cylinder storage room, where the sign includes the wording as a minimum "CAUTION: OXIDIZING GAS(ES) STORED WITHIN NO SMOKING." Storage is planned so cylinders are used in order of which they are received from the supplier. Empty cylinders are segregated from full cylinders. When facility employs cylinders with integral pressure gauge, a threshold pressure considered empty is established. Empty cylinders are marked to avoid confusion. Cylinders stored in the open are protected from weather. 11.3.1, 11.3.2, 11.3.3, 11.3.4, 11.6.5 (NFPA 99)			
	Based on observation and interview, the facility failed to ensure 1 of 1 storage locations of nonflammable gases equal to or greater than	K 0923	**Munster Med Inn** **Life Safety Code Recertification and State Licensure Survey:**	09/03/2021

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	3000 cubic feet on the third floor were secured against unauthorized entry. NFPA 99, Health Care Facilities Code, 2012 Edition, Section 11.3.2.1 states storage locations shall be outdoors in an enclosure or within an enclosed interior space of noncombustible or limited combustible construction, with doors (or gates outdoors) that can be secured against unauthorized entry. This deficient practice could affect 20 residents and staff in the vicinity of the oxygen storage and transfilling room. Findings include: Based on observations with the Maintenance Director and Corporate Facilities Engineer during a tour of the facility from 11:20 a.m. to 1:25 p.m. on 08/30/21, the corridor entry door to the oxygen storage and transfilling room on the third floor was equipped with a lock or other means to secure against unauthorized entry; however the key was in the doorknob. The room, located next to resident room 324, contained over one liquid oxygen containers and over two 'E' type cylinders. Based on interview at the time of the observation, the Corporate Facilities Engineer agreed the oxygen storage and transfilling room was not secure against unauthorized entry due to the key being in the doobknob lock. During the exit conference with the facility Maintenance Director and the Property Manager at 1:56 p.m., no additional information or evidence could be provided contrary to this deficient finding. 3.1-19(b)		**8-30-2021** K (923) Please accept the following as the facility's plan of correction. This plan of correction does not constitute an admission of guilt or liability by the facility and is submitted only in response to the regulatory requirement. **What corrective action will be accomplished for those residents found to have been affected by the deficient practice?** *The key in oxygen storage room door was immediately removed during the survey.* **How will the facility identify other residents having the potential to be affected by the same deficient practice?** *The deficient practice has the potential to affect all residents, and visitors in the event they gained access to an unauthorized area.* **What measures will the facility take or what systems will the facility alter to ensure that the problem will be corrected and will not recur?** *All staff was educated on securing oxygen room door. A weekly audit of all oxygen rooms for 3 months will be conducted to ensure compliance.*	

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	155131	A. BUILDING 03 B. WING	08/30/2021

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			How will the corrective action be monitored to ensure the deficient practice will not recur and what quality assurance program will be put into place? *Copy of audit will be reviewed at safety committee meeting for a duration of 3 months. All other deficient practices will be immediately corrected upon occurrence.* **Date of Completion: 9/3/2021**	