

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155131	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>03</u> B. WING _____	X3) DATE SURVEY COMPLETED 03/26/2015
--	---	---	---

NAME OF PROVIDER OR SUPPLIER MUNSTER MED-INN	STREET ADDRESS, CITY, STATE, ZIP CODE 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
--------------------	--	---------------	---	----------------------

K 000 Bldg. 03	<p>A Life Safety Code Recertification and State Licensure Survey was conducted by the Indiana State Department of Health in accordance with 42 CFR 483.70(a).</p> <p>Survey Date: 03/26/15</p> <p>Facility Number: 000056 Provider Number: 155131 AIM Number: 100289450</p> <p>Surveyor: Bridget Brown, Life Safety Code Specialist</p> <p>At this Life Safety Code survey, Munster Med-Inn was found not in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.70(a), Life Safety from Fire and the 2000 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 18, New Health Care Occupancies and 410 IAC 16.2.</p> <p>This six story facility with a 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</p>	K 000	Please accept the following as the facility's credible allegation of compliance. 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.	
-----------------------	---	-------	--	--

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155131	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>03</u> B. WING _____	X3) DATE SURVEY COMPLETED 03/26/2015
--	---	---	---

NAME OF PROVIDER OR SUPPLIER MUNSTER MED-INN	STREET ADDRESS, CITY, STATE, ZIP CODE 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
K 021 SS=E Bldg. 03	<p>corridors. Battery operated smoke detectors are installed in all resident rooms. The facility has the capacity for 225 and had a census of 209 at the time of this survey.</p> <p>All areas where the residents have customary access were sprinklered and all areas providing facility services were sprinklered.</p> <p>The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by the following:</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Any door in an exit passageway, stairway enclosure, horizontal exit, smoke barrier or hazardous area enclosure is held open only by devices arranged to automatically close all such doors by zone or throughout the facility upon activation of:</p> <p>a) the required manual fire alarm system;</p> <p>b) local smoke detectors designed to detect smoke passing through the opening or a required smoke detection system; and</p> <p>c) the automatic sprinkler system, if installed. 18.2.2.2.6 7.2.1.8.2 Based on observation and interview, the facility failed to ensure a double door set to a hazardous area such as a laundry larger than 100 square feet on 1 of 6</p>	K 021	<p>Specific Corrective Action Door coordinators were installed for the doorways in the basement laundry room on 03/27/15. Identification of other potential</p>	04/17/2015

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155131		X2) MULTIPLE CONSTRUCTION A. BUILDING <u>03</u> B. WING _____		X3) DATE SURVEY COMPLETED 03/26/2015	
NAME OF PROVIDER OR SUPPLIER MUNSTER MED-INN				STREET ADDRESS, CITY, STATE, ZIP CODE 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
K 025 SS=E Bldg. 03	<p>floors, was held open only by a device which would allow it to close upon activation of the fire alarm system. This deficient practice could affect staff, visitors, and any resident on the basement level.</p> <p>Findings include:</p> <p>Based on observation with the Maintenance Director on 03/26/15 at 1:30 p.m., one door in each of the two smoke barrier double door sets in the basement failed to close when tested twice to ensure its proper operation when the door with the astragal was closed first. There was no door coordinator to ensure the doors would always close in the correct sequence. The Maintenance Director said at the time of observations, a door coordinator had been ordered.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Smoke barriers are constructed to provide at least a one-hour fire resistance rating in accordance with 8.3. Smoke barriers may terminate at an atrium wall. Windows are protected by fire-rated glazing or by wired glass panels in approved frames. A minimum of two separate compartments are provided on each floor. Dampers are not required in duct penetrations of smoke barriers in fully ducted heating, ventilating, and air conditioning systems. 18.3.7.3,</p>				<p>deficiencies and corrective action. All other smoke barrier doors were checked to ascertain they closed in proper sequence upon activation of the fire alarm. No other instances of improper closure were identified. Systemic changes Smoke barrier doors with the automatic closures will be checked monthly by the Maintenance Director or designee to verify they are closing in proper sequence. Any doors that fail to close as required will be repaired or the closure mechanism replaced as necessary. Monitoring The Maintenance Director/designee will report the results of the monthly audit to the facility administrator. The administrator will coordinate repairs of any identified deficiency with the contracted provider of the door closure mechanism and Maintenance Director.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155131		X2) MULTIPLE CONSTRUCTION A. BUILDING <u>03</u> B. WING _____		X3) DATE SURVEY COMPLETED 03/26/2015	
NAME OF PROVIDER OR SUPPLIER MUNSTER MED-INN				STREET ADDRESS, CITY, STATE, ZIP CODE 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			
K 038 SS=E	<p>18.3.7.5, 18.1.6.3</p> <p>Based on observation and interview, the facility failed to ensure openings through a ceiling smoke barrier on 1 of 6 floors were sealed with a material to provide the 1/2 hour smoke resistance of the smoke barrier. LSC Section 8.3.6.1 requires the passage of building service materials such as pipe, cable or wire to be protected so the space between the penetrating item and the smoke barrier shall be filled with a material capable of maintaining the smoke resistance of the smoke barrier or be protected by an approved device designed for the specific purpose. This deficient practice could affect visitors, staff and 20 or more on the ground floor.</p> <p>Findings include:</p> <p>Based on observation with the Maintenance Director on 03/27/15 at 11:30 a.m., a cutout in the ceiling of the "ice melt" room for the passage of two pipes and wire were unsealed leaving unsealed gaps of one half to two inches. The maintenance Director said at the time of observation, he was unaware the gaps were not sealed.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD</p>	K 025	<p>Specific Corrective Action The identified openings in the room were sealed with NFPA-rated fire-stop caulk on 03/27/15. Identification of other potential deficiencies and corrective action. The maintenance director and assistants checked all other potential openings that were designed for the passage of pipes and/or wiring for openings that might allow for the passage of smoke. Any identified openings were sealed with NFPA-rated fire-stop caulk. Systemic Changes The Maintenance Director/designee will conduct rounds monthly on each floor to check for any openings between smoke barriers that may allow for the passage of smoke. Any identified openings will be appropriately sealed with smoke resistant material. Monitoring The Maintenance Director/designee will conduct the audits monthly. Any areas noted to need additional smoke resistant material will be reported to the Administrator for further direction on correction, as necessary.</p>	04/17/2015			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155131	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>03</u> B. WING _____	X3) DATE SURVEY COMPLETED 03/26/2015
--	---	---	---

NAME OF PROVIDER OR SUPPLIER MUNSTER MED-INN	STREET ADDRESS, CITY, STATE, ZIP CODE 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
Bldg. 03	<p>Exit access is arranged so that exits are readily accessible at all times in accordance with section 7.1. 18.2.1</p> <p>Based on observation and interview, the facility failed to ensure doors to exit rooms on 2 of 6 floors were provided with door knobs readily operated under all lighting conditions. LSC 7.2.1.5.4. requires where a latch or other similar device is provided, the method of operation of its releasing device must be obvious, even in the dark. The intention of this requirement is the method of release be one which is familiar to the average person. For example, a two step release, such as a knob and independent dead bolt, is not acceptable. In most occupancies, it is important that a single action unlatch the door. This deficient practice could affect visitors, staff and 10 or more residents on the second and sixth floors.</p> <p>Findings include:</p> <p>Based on observation with the Maintenance Director on 03/26/15 between 11:20 a.m. and 3:00 p.m., doors to the sixth floor activities room and the Unit 2 Director's office each had a dead bolt and door knob operating positive latches. In order to open the doors if the latches for both were engaged, two motions were required to open the door</p>	K 038	<p>Specific Corrective Action The door to the sixth floor activities room office and 2nd floor unit director's office were changed on 03/30/15 to door knob positive latching only. Identification of other potential deficiencies and corrective action All other offices, storage rooms and doors with positive latches were checked to ensure there was a single mechanism for unlatching. No other doors were identified as needing correction. Systemic changes The maintenance department were re-educated on the requirements for single release mechanisms for all positive latching doors, to ensure any replacements or repairs of existing knobs meet the standard for single action unlatching. The maintenance director will notify the administrator of any identified instances of non-compliance. Monitoring The Maintenance Director/designee will randomly check 5 positive latching doors per month for single motion release mechanisms. Any door lock found not in compliance with the standard will be immediately replaced. The maintenance director will report to the Administrator any requests for a lock that requires more than a single action to release, for re-education on the requirement of a single mechanism unlatching</p>	03/31/2015

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155131		X2) MULTIPLE CONSTRUCTION A. BUILDING <u>03</u> B. WING _____		X3) DATE SURVEY COMPLETED 03/26/2015	
NAME OF PROVIDER OR SUPPLIER MUNSTER MED-INN				STREET ADDRESS, CITY, STATE, ZIP CODE 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			
K 062 SS=E Bldg. 03	<p>to exit the rooms. The Maintenance Director acknowledged at the time of observation, each of these doors could require more than a single action to open the door.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 18.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5</p> <p>Based on record review and interview, the facility failed to maintain 1 of 1 sprinkler systems without impairments. NFPA 25, Standard for the Inspection, Testing and Maintenance of Water-Based Fire Protection Systems, 5-4.1 requires any abnormality observed during inspection or testing shall be promptly reported to the person responsible for correcting the abnormality. NFPA 25, 1-4.4 requires the owner or occupant promptly shall correct or repair deficiencies, damaged parts or impairments found while performing the inspection, test and maintenance requirements of this standard. This deficient practice could affect all occupants.</p> <p>Findings include:</p>	K 062	<p>lock.</p> <p>Specific Corrective Action The Maintenance Director contacted the contracted sprinkler maintenance company and scheduled the repair.(See Attachment K062-Fire Pump Repair and Temporary Waiver Request K0062) Identification of other potential deficiencies and corrective action The Maintenance Director reviewed all other inspection reports to ensure recommendations were addressed. No other instances of non-compliance was noted. Systemic changes The Maintenance Director will review all inspection reports with the Plant Operations consultant and Administrator as they are received for recommendations for repair. Any necessary corrections will be coordinated through the Plant Operations consultant, in conjunction with the Maintenance Director and Administrator to</p>	04/25/2015			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155131	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>03</u> B. WING _____		X3) DATE SURVEY COMPLETED 03/26/2015
NAME OF PROVIDER OR SUPPLIER MUNSTER MED-INN			STREET ADDRESS, CITY, STATE, ZIP CODE 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	
K 067 SS=E Bldg. 03	<p>Based on review of the July 30, 2014 annual Fire Pump Testing & Inspection report with the Maintenance Director on 03/26/15 at 4:05 p.m., deficiencies in the operation of the fire pump were identified and an inoperative valve was identified. The report noted, "the pump was performing 13.7% off design at shut off condition, 2.9% off design at rated condition, and was 5% off design at the 150% of rated condition flow point. NFPA 25 allows for a 5% performance deficiency." The report also noted, "Our technician noted that the casing relief valve is not working and should be replaced." The Maintenance Director said at the time of record review he was unaware of the fire pump defects and had no knowledge or documentation to evidence the noted deficiencies had been corrected.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Heating, ventilating, and air conditioning comply with the provisions of section 9.2 and are installed in accordance with the manufacturer's specifications. 9.2, 18.5.2.1, 18.5.2.2, NFPA 90A Based on record review and interview,</p>	K 067	<p>ensure continued safe operations of the facility. Monitoring The Maintenance Director will provide the Administrator with all inspections reports as received. The Administrator will acknowledge receipt of the same by dated signature. The Maintenance Director will provide the Administrator a copy of the completed repair by the contracted company, which again will be acknowledged by dated signature of the Administrator. The signed copy of completion shall be retained by the Maintenance Director with the original inspection which noted the deficiency.</p> <p>Specific Corrective Action The</p>	04/22/2015	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155131	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>03</u> B. WING _____		X3) DATE SURVEY COMPLETED 03/26/2015
NAME OF PROVIDER OR SUPPLIER MUNSTER MED-INN			STREET ADDRESS, CITY, STATE, ZIP CODE 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	
	<p>the facility failed to ensure dampers in the ductwork and walls serving 1 of 6 floors were inspected and provided necessary maintenance at least every four years in accordance with NFPA 90A. LSC 19.5.2.1 refers to Section 9.2. LSC 9.2.1 requires air conditioning, heating, ventilating ductwork and related equipment shall be in accordance with NFPA 90A, Standard for the Installation of Air-Conditioning and Ventilating Systems. NFPA 90A, 1999 Edition, 3.4.7, Maintenance, requires at least every 4 years, fusible links (where applicable) shall be removed; all dampers shall be operated to verify they fully close; the latch, if provided, shall be checked, and moving parts shall be lubricated as necessary. Furthermore, fire dampers shall be provided with an approved means of access large enough to permit inspection and maintenance of the damper and its operating parts. This deficient practice affects occupants of the basement in a six story building..</p> <p>Findings include:</p> <p>Based on observation with the Maintenance Director on 03/26/15 at 2:45 p.m., a damper was located in wall above the smoke barrier door near the laundry and in the corridor wall above the environmental services storage room. A</p>		<p>dampers # 7, 8 ,9, 11, 12 and 13 noted in the inspection report were inspected on 04/21/15by the contracted fire safety inspection company. The dampers above the smoke barrier door near laundry and the corridor wall above the environmental services storage room were inspected and added to the inspection report. Identification of other potential deficiencies and corrective action The maintenance director and the fire safety contractor inspected the balance of the building to ensure all other dampers were listed on the inspection report and accessible to inspection. No other dampers were noted as inaccessible or unlisted. Systemic changes The Maintenance Director will review all inspection reports with the Plant Operations consultant and Administrator as they are received for recommendations for repair. Any necessary corrections will be coordinated through the Plant Operations consultant, in conjunction with the Maintenance Director and Administrator to ensure continued safe operations of the facility. Monitoring The Maintenance Director will provide the Administrator with all inspections reports as received. The Administrator will acknowledge receipt of the same by dated signature. The Maintenance Director will provide the Administrator a copy of the completed repair by the</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155131		X2) MULTIPLE CONSTRUCTION A. BUILDING <u>03</u> B. WING _____		X3) DATE SURVEY COMPLETED 03/26/2015	
NAME OF PROVIDER OR SUPPLIER MUNSTER MED-INN				STREET ADDRESS, CITY, STATE, ZIP CODE 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
K 074 SS=E Bldg. 03	<p>review of the contractor Fire Damper Inspection Checklist dated 3-9-15 with the Maintenance Director on 03/26/15 at 3:15 p.m., noted 6 of 13 dampers on the list were not inspected. The report noted dampers number 7,8,9,11,12 and 13 were "not accessible." The damper located in wall above the smoke barrier door near the laundry and in the corridor wall above the environmental services storage room were not included in the report. The Maintenance Director said at the time of record review, he did not know why these dampers were not included on the inspection report. He acknowledged not all of the dampers had been inspected and tested.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Draperies, curtains, including cubicle curtains, and other loosely hanging fabrics and films serving as furnishings or decorations in health care occupancies are in accordance with provisions of 10.3.1 and NFPA 13, Standards for the Installation of Sprinkler Systems. Shower curtains are in accordance with NFPA 701.</p> <p>Newly introduced upholstered furniture within health care occupancies meets the criteria specified when tested in accordance with the methods cited in 10.3.2 (2) and 10.3.3. 18.7.5.1, 1, NFPA 13</p>				<p>contracted company, which again will be acknowledged by dated signature of the Administrator. The signed copy of completion shall be retained by the Maintenance Director with the original inspection which noted the deficiency.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155131		X2) MULTIPLE CONSTRUCTION A. BUILDING <u>03</u> B. WING _____		X3) DATE SURVEY COMPLETED 03/26/2015	
NAME OF PROVIDER OR SUPPLIER MUNSTER MED-INN				STREET ADDRESS, CITY, STATE, ZIP CODE 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			
	<p>Newly introduced mattresses meet the criteria specified when tested in accordance with the method cited in 10.3.2 (3) , 10.3.4, 18.7.5.3</p> <p>Based on observation and interview, the facility failed to ensure the mesh provided for privacy curtains installed in resident rooms on 1 of 5 floors was at least 1/2 inch diagonal mesh or a 70 percent open weave extending 18 inches below the sprinkler deflectors in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems. This deficient practice could affect visitors, staff and 20 or more residents on the fourth floor.</p> <p>Findings include:</p> <p>Based on observations with the Maintenance Director on 03/26/15 between 11:35 a.m. and 3:00 p.m., one or more privacy curtains hanging in resident rooms 411, 413, 421, 419, 404, 405, 406, 408, 414, 418, 420, and 422, lacked 1/2 inch diagonal mesh or a 70 percent open weave top panel extending 18 inches below the sprinkler deflectors. The Maintenance Director acknowledged at the time of observations, the mesh was less than the minimum size permitted.</p> <p>3.1-19(b)</p>	K 074	<p>Specific corrective action New cubicle curtains have been ordered on 04/16/15 to replace the ones in the rooms identified. (See attachment K074-A, signed order for cubicle curtains and Temporary Waiver Request K0074.) Identification of other potential deficiencies and corrective action. The Environmental Services Director and Administrator checked the cubicle curtains on the other floors of the facility for proper mesh size. No other cubicles with improper mesh were identified. Systemic change The Environmental Services Director will review with the Administrator any new purchases of cubicle curtains prior to purchase to ensure proper mesh size is an intrinsic component of the curtain. Monitoring The Environmental Services Director will maintain a copy of the specifications for each purchase of cubicle curtains to assure mesh size meets the standard. The specifications will be available upon request by any licensing agency.</p>	04/16/2015			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155131		X2) MULTIPLE CONSTRUCTION A. BUILDING <u>03</u> B. WING _____		X3) DATE SURVEY COMPLETED 03/26/2015	
NAME OF PROVIDER OR SUPPLIER MUNSTER MED-INN				STREET ADDRESS, CITY, STATE, ZIP CODE 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			
K 161 SS=E Bldg. 03	<p>NFPA 101 LIFE SAFETY CODE STANDARD All elevators, escalators, and conveyors comply with ASME/ANSI A17.1, Safety Code for Elevators and Escalators. 9.4, 18.5.3 Based on observation, record review and interview, the facility failed to ensure 2 of 2 elevators were in compliance with ASME/ANSI A17.1, Safety Code for Elevators and Escalators. This deficient practice could affect visitors, staff and 50 or more residents relying on the elevators.</p> <p>Findings include:</p> <p>Based on observation with the Maintenance Director on 03/26/15 at 3:00 p.m., the elevator certificates of inspection for the two elevators had expired 11/21/14. The Maintenance Director said at the time of observation, the elevators had been inspected and certificates of inspection were not going to be issued until deficiencies noted were corrected. Deficiencies included incomplete Fire Service wiring for Fireman's Phase II emergency in-car service, Hall Position Indicators and installation of a new door protection system to replace the tentatively repaired system on the south elevator. Proposals and quotes for the repair of the elevators were provided but the repairs were not</p>	K 161	<p>Specific Corrective Action The elevator repairs noted in the inspection have been approved. (See Temporary Waiver request K0161.) Identification of other potential deficiencies and corrective action No other outstanding recommendations exist that need repair for the elevator inspection certificates to be issued. Systemic change The Maintenance Director will review all inspection reports with the Plant Operations consultant and Administrator as they are received for recommendations for repair. Any necessary corrections will be coordinated through the Plant Operations consultant, in conjunction with the Maintenance Director and Administrator to ensure continued safe operations of the facility. Monitoring The Maintenance Director will provide the Administrator with all inspections reports as received. The Administrator will acknowledge receipt of the same by dated signature. The Maintenance Director will provide the Administrator a copy of the completed repair by the contracted company, which again will be acknowledged by dated signature of the Administrator. The signed copy of completion</p>	04/24/2015			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 04/23/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155131	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>03</u> B. WING _____		X3) DATE SURVEY COMPLETED 03/26/2015
NAME OF PROVIDER OR SUPPLIER MUNSTER MED-INN			STREET ADDRESS, CITY, STATE, ZIP CODE 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	
	yet scheduled. 3.1-19(b)		shall be retained by the Maintenance Director with the original inspection which noted the deficiency.		