

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155131	X2) MULTIPLE CONSTRUCTION A. BUILDING 03 B. WING _____	X3) DATE SURVEY COMPLETED  07/18/2012
--	---	--	---

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
--------------------	--	---------------	---	----------------------

K0000	<p>A Quality Assurance Walk-thru Survey was conducted by the Indiana State Board of Health.</p> <p>Survey Date: 07/18/12</p> <p>Facility Number: 000056 Provider Number: 155131 AIM number: 100289450</p> <p>Surveyor: W. Chris Greeney , Life Safety Code Specialist,</p> <p>At this Quality Assurance Walk-thru survey, Munster Med-Inn was found not in compliance with 410 IAC 16.2-3.1-19(ff).</p> <p>This six story facility with a basement was remodeled in 2008 and was determined to be of Type I (332) construction and was not fully sprinklered. The facility has a fire alarm system with smoke detection in the corridors and spaces open to the corridors. A battery operated smoke detector was present in each resident room. The facility has a capacity of 224 and had a census of 200 at the time of this survey.</p> <p>The facility was found not in compliance with state law in regard to sprinkler</p>	K0000		
-------	--	-------	--	--

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 03 B. WING _____		X3) DATE SURVEY COMPLETED  07/18/2012
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>coverage. An office on the fifth floor was not sprinklered. Additionally a basement elevator equipment room was not sprinklered. The facility was found in compliance with state law in regard to smoke detector coverage.</p> <p>All areas where the residents have customary access were sprinklered. All areas providing facility services were sprinklered except for the fifth floor social services office and the basement elevator equipment room.</p> <p>Quality Review by Robert Booher, Life Safety Code Specialist-Medical Surveyor on 07/27/12.</p> <p>The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by the following:</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155131		X2) MULTIPLE CONSTRUCTION A. BUILDING 03 B. WING _____		X3) DATE SURVEY COMPLETED 07/18/2012	
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
K9999	<p>State Findings</p> <p>3.1-19 ENVIRONMENT AND PHYSICAL STANDARDS</p> <p>3.1-19(ff) A health facility licensed under 16-28 and this rule must do the following:</p> <p>(1) Have an automatic sprinkler system installed throughout the facility before July 1, 2012.</p> <p>(2) If an automatic sprinkler system is not installed throughout the health care facility before July 1, 2010, submit before July 1, 2010 a plan to the department for completing the installation of the automatic sprinkler system before July 1, 2012.</p> <p>(3) Have a battery operated or hard-wired smoke detector in each resident's room before July 1, 2012.</p> <p>This State Rule has not been met as evidenced by: Based on observation and interview, the facility failed to ensure all areas providing services to the facility were sprinklered. This deficient practice could affect 200 residents in the facility.</p> <p>Findings include:</p> <p>1. Based on observation with the</p>			K9999	<p>K9999-amended response 8/29/12</p> <p>Submission of this response and Plan of Correction is not legal admission that a deficiency exists, or that a Statement of Deficiency exists, or that a Statement of Deficiency was correctly cited. Submission of this response is not to be construed as an admission of any admission of a deficiency against the facility, the Administrator, or any employees who draft or may be discussed in this response and plan of correction. In direct response to the five questions listed on page one of the letter to this facility dated July 30, 2012, the facility offers the following:</p> <p>1. What corrective actions will be accomplished for those residents found to have been affected by the deficient practice?</p> <p>As it relates to observation #1 upon identification and notification of the requirement for the basement elevator equipment room to be sprinklered, arrangements were made for a sprinkler to be installed. The sprinkler installation has been scheduled to take place on Wednesday, August 29, 2012.</p> <p>As it relates to observation #2 upon identification and notification of the requirement to have the fifth floor Social Service office sprinklered the wall that was constructed between said office and adjoining sprinklered</p>		08/29/2012

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155131	X2) MULTIPLE CONSTRUCTION A. BUILDING 03 B. WING _____	X3) DATE SURVEY COMPLETED  07/18/2012
--	---	--	---

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>Maintenance Supervisor during a facility tour from 1:00 p.m. to 2:55 p.m. on 7/18/12, the basement elevator equipment room was not sprinklered. The walls were cinder block construction with a steel door, however the ceiling was constructed of sheetrock and contained an access panel. The Maintenance Supervisor removed the access panel and the sheetrock measured at 5/8" thickness. The Maintenance Supervisor during the observation confirmed the room was not sprinklered and the ceiling was constructed of one layer of sheetrock only 5/8" thick.</p> <p>2. Based on observation with the Maintenance Supervisor during a facility tour from 1:00 p.m. to 2:55 p.m. on 7/18/12, an office area on the fifth floor was not sprinklered. The maintenance supervisor interviewed during the observation, indicated the office was not sprinklered because a wall had been constructed turning one space into two offices and the room which was not sprinklered was the social services office for that floor.</p> <p>3.1-19(ff)</p>		<p>office was removed.</p> <p>2. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken.</p> <p>As it relates to observation #1 the facility is confident that by installing a sprinkler head in the basement elevator equipment room this will ensure that no like circumstances will occur.</p> <p>As it relates to observation #2 the facility is confident that removal of the wall between the fifth floor Social Service office and the adjoining sprinklered office no like circumstances will occur.</p> <p>3. What measures will be put into place or what systematic changes will be made to ensure the deficient practice does not recur? As it relates to observation #1 the facility Building Manager will maintain documentation of the installation of the sprinkler head in the basement elevator equipment room.</p> <p>As it relates to observation # 2 the facility Building Manager will maintain documentation of the removal of the wall between the Social Service and the adjoining sprinklered office.</p> <p>4. How the corrective actions will be monitored to ensure the deficient practice will not recur. As it relates to observation #1 the facility Building Manager will</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155131	X2) MULTIPLE CONSTRUCTION A. BUILDING 03 B. WING _____	X3) DATE SURVEY COMPLETED  07/18/2012
--	---	--	---

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>maintain documentation of the installation of the sprinkler head in the basement elevator equipment room.</p> <p>As it relates to observation #2 the facility Building Manager will maintain documentation of the removal of the wall between the fifth floor Social Service office and the adjoining sprinklered office.</p> <p>5. By what date will the systematic changes be completed? August 29, 2012.</p>	