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

	AND PLAN OF CORRECTION IDENTIFICATION NUMBER		l í	ILDING	ONSTRUCTION	(X3) DATE COMPL 12/06/	ETED
	PROVIDER OR SUPPLIER		•	7935 C	ADDRESS, CITY, STATE, ZIP COD ALUMET AVE FER, IN 46321		
(X4) ID PREFIX	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	(X5) COMPLETION
TAG E 0000	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
Bldg		paredness Survey was diana Department of Health in CFR 483.73.	E 00	000	The facility kindly requests a creview	lesk	
	Med-Inn, was found Emergency Prepare Medicare and Medi and Suppliers, 42 C	289450 Preparedness survey, Munster I in compliance with dness Requirements for caid Participating Providers FR 483.73 certified beds. At the time of us was 177.					
K 0000							l l
Bldg. 03	Licensure Survey w Department of Heal 483.90(a).  Survey Date: 12/06  Facility Number: 0 Provider Number: AIM Number: 1000  At this Life Safety 0	00056 155131	K 00	000	The facility kindly requests a creview	lesk	
LABORATOR	Y DIRECTOR'S OR PRO	/IDER/SUPPLIER REPRESENTATIVE'S SI	IGNATURE		TITLE		(X6) DATE

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

(X6) DATE

Robert Petty Administrator 12/13/2022

Any defiencystatement ending with an asterisk (\*) denotes a deficency which the institution may be excused from correcting providing it is determin other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 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 disclo 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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PRINTED: 12/16/2022 FORM APPROVED OMB NO. 0938-039

	OF CORRECTION	IDENTIFICATION NUMBER  155131	A. BUILDING  B. WING	03	COMPLETED 12/06/2022
	ROVIDER OR SUPPLIER		7935 C	ADDRESS, CITY, STATE, ZIP COD ALUMET AVE ER, IN 46321	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
K 0300	Life Safety from Fir National Fire Protect Life Safety Code (L Health Care Occupated This six-story facility determined to be of was fully sprinklere system with hard with corridors and spaces Battery operated small resident rooms. By a 200-kW dieselfacility has the capated of 177 at the time of All areas where the access were sprinkle facility services were Quality Review con	42 CFR Subpart 483.90(a), re and the 2012 edition of the stion Association (NFPA) 101, SC), Chapter 19, Existing success and 410 IAC 16.2.  Type I (332) construction and d. The facility has a fire alarm red smoke detection in the sopen to the corridors.  The building is fully protected spowered generator. The city for 225 and had a census of this survey.  This survey.  Tresidents have customary pered and all areas providing the sprinklered.			
SS=E Bldg. 03	Section 18.3 and requirements that provided K-tags, b information, along Safety Code or NF should be included Based on observation failed to replace 2 of smoke alarms install in accordance with Edition, Section 14.	KS section any LSC 19.3 Protection are not addressed by the ut are deficient. This with the applicable Life FPA standard citation, d on Form CMS-2567. In and interview, the facility of over 100 battery operated led in resident sleeping rooms NFPA 72. NFPA 72, 2010 4.8.1 states unless otherwise e manufacturer's published	K 0300	Munster Med Inn Life Safety Code Recertification and State Licensure Survey: 12-6-2022 K 300 Please accept the following as	

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING COMPLETED 03 B. WING 12/06/2022 155131 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 7935 CALUMET AVE MUNSTER MED-INN MUNSTER, IN 46321 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE instructions, single- and multiple-station smoke facility's plan of correction. This alarms shall be replaced when they fail to respond plan of correction does not to operability tests but shall not remain in service constitute an admission of guilt or longer than 10 years from the date of manufacture. liability by the facility and is This deficient practice could affect over 30 submitted only in response to the residents, staff, and visitors in the vicinity of regulatory requirement. resident rooms 108 & 216. What corrective action will be Findings include: accomplished for those residents found to have been Based on observations with the Maintenance affected by the deficient Director and Corporate Facilities Engineer on practice? resident rooms 108 12/06/22 during a tour of the facility from 9:50 a.m. and 216 battery operated smoke to 12:25 p.m., manufacturer's documentation detectors had a service life of ten affixed to the battery operated smoke alarms years and needed replaced. Room installed on the ceiling in resident sleeping rooms 108 and 216 smoke detectors 108 & 216 indicated each device was have been replaced and working manufactured 07/26/2011 and 05/25/2011 properly. respectively. Based on interview at the time of How will the facility identify each observation, the Maintenance Director agreed the aforementioned smoke alarms were other residents having the more than ten years old. potential to be affected by the same deficient practice? The These findings were reviewed with the deficient practice has the potential Maintenance Director and Corporate Facilities to affect residents in rooms108 Engineer during the exit conference. and 216 if the smoke detector were to fail during a fire 3.1-19(b)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 re-educated on the life span of a battery operated smoke detectors. All battery operated smoke detectors over ten years old have replaced to ensure compliance.

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	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	· ′	PLE CONSTRUCTION	ſ ´	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER  155131	A. BUILDII B. WING	NG <u>03</u>	<del>-</del> I	LETED 5/2022	
		133131	<u> </u>		_	0/2022	
NAME OF P	PROVIDER OR SUPPLIER			REET ADDRESS, CITY, STATE, ZIP C 35 CALUMET AVE	OD		
MUNSTE	R MED-INN			JNSTER, IN 46321			
(X4) ID		STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF COR	RECTION	(X5)	
PREFIX TAG	`	CY MUST BE PRECEDED BY FULL  LSC IDENTIFYING INFORMATION	PREF TA	CROSS-REFERENCED TO THE A	PPROPRIATE	COMPLETION DATE	
K 0345 SS=C Bldg. 03	in accordance with complying with the National Electric C National Fire Alarr Records of system and testing are rea 9.6.1.3, 9.6.1.5, N Based on observation failed to maintain that it had accurate accordance with the 2012 edition, Section 2010 edition 2010	n - Testing and m is tested and maintained n an approved program requirements of NFPA 70, code, and NFPA 72, m and Signaling Code. n acceptance, maintenance adily available.	K 0345	How will the corrective monitored to ensure the practice will not recursed quality assurance proget into place? Smoke replacement requirement reviewed at the safety meeting for a duration months. All other deficies practices will be immediately assurance or corrected upon occurred.  Date of Completion: 1  Munster Med Inn Life Safety Code Recertification and Staticensure Survey: 12-16, 345  Please accept the follotiacility's plan of correction does constitute an admission liability by the facility at	e deficient and what ram will be a detector ents will be committee of 3 sient diately ence.  2/13/2022  ate 6-2022  wing as the sion. This is not guilt or	12/13/2022	

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DEPARTMENT OF HEALTH AND HUMAN SERVICES OMB NO. 0938-039 STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING COMPLETED 03 B. WING 12/06/2022 155131 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 7935 CALUMET AVE MUNSTER MED-INN MUNSTER, IN 46321 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX PREFIX COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE submitted only in response to the Based on observations with the Maintenance regulatory requirement. Director and Corporate Facilities Engineer during a tour of the facility from 9:50 a.m. to 12:25 p.m. on What corrective action will be 12/06/22, the date and the time of day for the main accomplished for those fire alarm control panel were incorrect. The display residents found to have been read the date as February 13, 2006 and the time of affected by the deficient day as 2:13 a.m. at 11:30 a.m. Based on interview at practice? A call was place to the time of the observations, the Corporate Koorsen fire alarm to make Facilities Engineer agreed the main fire alarm repairs/correction to reset panel. control panel did not display the correct date and Panel now showing correct time the correct time of day. and date. This finding was reviewed with the Maintenance How will the facility identify Director and Corporate Facilities Engineer during other residents having the the exit conference. potential to be affected by the same deficient practice? The 3.1-19(b) deficient practice has the potential to affect all residents, staff and visitors. The panel is fully functional and now displays the correct date 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 re-educated to inspect panel for correct information. A weekly random audit will be conducted for 3 months to ensure compliance.

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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

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DEPARTMENT OF HEALTH AND HUMAN SERVICES							RM APPROVED
CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO.							B NO. 0938-039
STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MU	JLTIPLE CO	NSTRUCTION	(X3) DATE	SURVEY
AND PLAN (	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	ILDING	03	COMPLETED	
		155131	B. WI	B. WING		12/06/	2022
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD 7935 CALUMET AVE			
MUNSTE	R MED-INN			MUNST	ER, IN 46321		
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE

TAG REGULATORY OR LSC IDENTIFYING INFORMATION  TAG  CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)  DAT  be reviewed at safety committee meeting for a duration of 3 months. All other deficient practices will be immediately	PLETION ATE
TAG REGULATORY OR LSC IDENTIFYING INFORMATION  TAG DEFICIENCY)  be reviewed at safety committee  meeting for a duration of 3  months. All other deficient  practices will be immediately	ATE
meeting for a duration of 3 months. All other deficient practices will be immediately	
corrected upon occurrence.	
K 0355 SS=D Bldg. 03 NFPA 101 Portable Fire Extinguishers Portable fire extinguishers are selected, installed, inspected, and maintained in accordance with NFPA 10, Standard for Portable Fire Extinguishers. 18.3.5.12, 19.3.5.12, NFPA 10 Based on observation and interview, the facility failed to inspect 1 of 1 portable fire extinguishers in the generator room each month. NFPA 10, Standard for Portable Fire Extinguishers, Section 7.2.1.2 states fire extinguishers shall be inspected either manually or by means of an electronic device / system at a minimum of 30-day intervals. Section 7.2.2 states periodic inspection or electronic monitoring of fire extinguishers shall include a check of at least the following items: (1) Location in designated place (2) No obstruction to access or visibility (3) Pressure gauge reading or indicator in the operable range or position (4) Fullness determined by weighing or hefting for self expelling-type extinguishers, and pump tanks (5) Condition of tires, wheels, carriage, hose, and nozzle for wheeled extinguishers (6) Indicator for nonrechargeable extinguishers using pushto-test pressure indicators.  Date of Completion: 12/13/2022   K 0355  Munster Med Inn Life Safety Code Recertification and State Licensure Survey: 12-6-2022 K 355 Please accept the following as the facility splan 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? Fire extinguisher in generator room had not had a monthly inspection. All fire extinguishers equire a monthly	3/2022

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STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155131		(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 03	(X3) DATE SURVEY COMPLETED 12/06/2022	
	PROVIDER OR SUPPLIER		7935 C	ADDRESS, CITY, STATE, ZIP COD FALUMET AVE TER, IN 46321	
(X4) ID PREFIX	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	
TAG	Section 7.2.4.1 state inspections shall ke extinguishers insper require corrective a where at least mont conducted, the date performed and the inperforming the inspection 7.2.4.4 requare conducted, reconshall be kept on a tax extinguisher, on an maintained on file, Section 7.2.4.5 requal demonstrate that at inspections have be practice could affect generator room.  Findings include:  Based on observation with the Maintenant Facilities Engineer monthly inspection extinguisher located missing documente November 2022. At was performed 09/1 vendor. Based on in observation, the Mathe extinguisher location missing two months.  This finding was different find	es personnel making manual ep records of all fire eted, including those found to etion. Section 7.2.4.3 requires hly manual inspections are the manual inspection was nitials of the person ection shall be recorded. Eiters where manual inspections of for manual inspections of a record of the person etion shall be recorded. Eiters where manual inspections of a record of the fire inspection checklist or by an electronic method. Eiters records shall be kept to least the last 12 monthly en performed. This deficient of the tate of the triangular to the tate of the triangular to the tag on the ABC fire in the generator room was do inspection for October and mula fire extinguisher testing 2/2022 by the contracted enterview at the time of intenance Director confirmed atted in the generator room was so of documented inspections.	TAG	inspection All fire extinguisher have been inspected.  How will the facility identify other residents having the potential to be affected by the same deficient practice? The deficient practice has the potential staff in the vicinity the generator room if the fire extinguisher were to fail during fire  What measures will the facility alter to ensure that the problem will be corrected an will not recur? Maintenance department was educated on checking the fire extinguishers monthly. A weekly random at will be conducted for 3 monthensure compliance.  How will the corrective action monitored to ensure the defici practice will not recur and what quality assurance program will put into place? Copy of audit be reviewed at safety committed meeting for a duration of 3 months. All other deficient practices will be immediately corrected upon occurrence.  Date of Completion: 12/13/20	e e e e e e e e e e e e e e e e e e e

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CENTERS FOR	R MEDICARE & MEDIC	AID SERVICES				OM	IB NO. 0938-039	
STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	03	COMPI	LETED	
		155131	B. W	ING		12/06	/2022	
NAME OF P	PROVIDER OR SUPPLIER	8			ADDRESS, CITY, STATE, ZIP COD			
					ALUMET AVE			
MUNSTE	R MED-INN			MUNST	ER, IN 46321			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID			(X5)	
PREFIX		ICY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		COMPLETION	
TAG	·	R LSC IDENTIFYING INFORMATION		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	DATE	
K 0363	NFPA 101	CESC IDENTIFY TING INFORMATION	_	1710			DATE	
SS=D	Corridor - Doors							
Bldg. 03	Corridor - Doors							
		corridor openings in other						
	· ·	losures of vertical openings,						
		s areas resist the passage						
		made of 1 3/4 inch						
	solid-bonded core	wood or other material						
	capable of resistin	ng fire for at least 20						
	minutes. Doors in	fully sprinklered smoke						
	compartments are	only required to resist the						
	passage of smoke	e. Corridor doors and doors						
	to rooms containir	ng flammable or						
		rials have positive latching						
	hardware. Roller la	atches are prohibited by						
		hese requirements do not						
		spaces that do not contain						
	flammable or com	-						
		en bottom of door and floor						
		ceeding 1 inch. Powered						
	_	vith 7.2.1.9 are permissible						
		device capable of keeping						
	l -	hen a force of 5 lbf is						
		no impediment to the						
		rs. Hold open devices that						
	_							
		door is pushed or pulled are						
	l '	ed protective plates of						
	1	re permitted. Dutch doors						
		6 are permitted. Door						
		beled and made of steel or						
		compliance with 8.3,						
	unless the smoke							
	1 -	fire window assemblies are						
	1	n sprinklered compartments						
		ctions in area or fire						
	resistance of glass	s or frames in window						
	assemblies.							
	19.3.6.3, 42 CFR	Parts 403, 418, 460, 482,						

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STATEMEN	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	A. BUILDING 03			COMPLETED	
		155131	B. W	ING	_	12/06	/2022	
		<u> </u>	-	STREET A	ADDRESS, CITY, STATE, ZIP COD			
NAME OF P	PROVIDER OR SUPPLIEF	8			ALUMET AVE			
MUNSTE	R MED-INN				TER, IN 46321			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX	·	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION	
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE	
		(S details of doors such as						
	-	ngs, automatics closing						
	devices, etc.	1:4 : 4 6 774	17.0	2.62	l., , ., .,		12/12/2022	
		on and interview, the facility f over 100 resident room	K 0	363	Munster Med Inn		12/13/2022	
		provided with a means			Life Safety Code			
		the door closed, had no			Recertification and State			
		ing, latching and would resist			Licensure Survey: 12-6-2022 K 363			
	*	ke. This deficient practice			Please accept the following as	s the		
	could affect 2 reside	-			facility's plan of correction. Th			
	- 5 and annot 2 1001d				plan of correction does not			
	Findings include:				constitute an admission of gui	lt or		
	1 mangs metade.				liability by the facility and is			
	Based on observation with the Maintenance				submitted only in response to	the		
	Director and Corpo	rate Facilities Engineer on			regulatory requirement.			
	-	our of the facility at 11:08 a.m.,						
	the corridor door to	resident room 210 did not			What corrective action will b	е		
	latch into the frame	when tested. Based on			accomplished for those			
	interview at the tim	e of observation, the			residents found to have been	n		
	Maintenance Direct	tor agreed the corridor door			affected by the deficient			
		the door frame, and would			practice? Resident room doo	or		
	work on the door so	o it would latch.			210 did not latch when closed			
					Door was adjusted and tested	<b>!</b> .		
		viewed with the Maintenance			Door now latching properly.			
	•	rate Facilities Engineer at the						
	exit conference.				How will the facility identify			
	3 1 10/b)				other residents having the			
	3.1-19(b)				potential to be affected by the			
					same deficient practice? The deficient practice has the pote			
					to affect resident in room 210			
					door did not latch during a fire			
					acor did not later during a me	•		
					What measures will the facili	ity		
					take or what systems will the	-		
					facility alter to ensure that th			
					problem will be corrected an			
					will not recur? Maintenance			
					department was educated on	the		
					need for doors to latch proper	h, A	İ	

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION		NSTRUCTION	(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING 03 COMPLE			ETED	
				· · · · · · · · · · · · · · · · · · ·			/2022
			<del></del>			12,00	
NAME OF P	ROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP COD		
					ALUMET AVE		
MUNSTE	R MED-INN			MUNST	ER, IN 46321		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL	I	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OF	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	16	DATE
					weekly random audit of doors	will	
					be conducted for 3 months to	)	
					ensure compliance.		
					,		
					How will the corrective action	be	
					monitored to ensure the defici	ent	
					practice will not recur and wha	at	
					quality assurance program wil		
					put into place? Copy of audit		
					be reviewed at safety committ		
					meeting for a duration of 3		
					months. All other deficient		
					practices will be immediately		
					corrected upon occurrence.		
					φ.		
					Date of Completion: 12/13/20	22	
					•		
K 0374	NFPA 101						
SS=E	Subdivision of Bui	lding Spaces - Smoke					
Bldg. 03	Barrie						
	Subdivision of Bui	lding Spaces - Smoke					
	Barrier Doors						
	2012 EXISTING						
	Doors in smoke ba	arriers are 1-3/4-inch thick					
	solid bonded woo	d-core doors or of					
		esists fire for 20 minutes.					
		e plates of unlimited height				ļ	
		ors are permitted to have				ļ	
		assemblies per 8.5. Doors				ļ	
	_	automatic-closing, do not				ļ	
		nd are not required to swing				ļ	
	in the direction of	egress travel. Door opening				ļ	
	provides a minimu	ım clear width of 32 inches				ļ	
	for swinging or ho					ļ	
	19.3.7.6, 19.3.7.8						

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Based on observation and interview, the facility

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K 0374

Facility ID: 000056

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**Munster Med Inn** 

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	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155131	(X2) MULTIPLE CO A. BUILDING B. WING	onstruction 03	(X3) DATE SURVEY COMPLETED 12/06/2022
	PROVIDER OR SUPPLIER		7935 C	ADDRESS, CITY, STATE, ZIP COD CALUMET AVE TER, IN 46321	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI, DEFICIENCY)	(X5) COMPLETION DATE
TAG	failed to ensure 1 or would restrict the m 20 minutes. LSC 1 barriers shall comple 8.5.4.1 requires doe the opening leaving necessary for prope practice could affect undetermined number the main entrance a Findings include:  During a tour of the Director and Corpo 12/06/22 at 11:59 a doors near the Admiclose due to a malfit doors remained appleaded. Based on in observation, the MacCorporate Facilities doors did not fully of		TAG	Life Safety Code Recertification and State Licensure Survey: 12-6-2022 K 374 Please accept the following a facility's plan of correction. The plan of correction does not constitute an admission of guiliability by the facility and is submitted only in response to regulatory requirement.  What corrective action will be accomplished for those residents found to have been affected by the deficient practice? The coordinator of fire/smoke doors hallway by face Administration offices has been adjusted and tested. Doors all now closing and latching properties.	s the his hilt or the heront en ree herly.
		viewed with the Maintenance rate Facilities Engineer at 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 a did not close and latch during fire.  What measures will the facilitate or what systems will the facility alter to ensure that the problem will be corrected and will not recur? Maintenance department was educated on of coordinators on fire and sind doors and need for doors to continue.	e ential and doors a lity e ne nd luse noke

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Facility ID: 000056

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		r í	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER		A. BUILDING 03 B. WING		COMPLETED 12/06/2022	
		155131	B. W	ING		12/06/	2022
	PROVIDER OR SUPPLIER			7935 C	ADDRESS, CITY, STATE, ZIP COD ALUMET AVE 'ER, IN 46321		
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIE		ID	BROWDENG N. IN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
					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 monitored to ensure the deficipractice will not recur and what quality assurance program will put into place? Copy of audit be reviewed at safety committed meeting for a duration of 3	ent at I be <i>will</i>	
					months. All other deficient practices will be immediately corrected upon occurrence.  Date of Completion: 12/13/20	22	
K 0741 SS=E Bldg. 03	shall include not le provisions: (1) Smoking shall ward, or compartn liquids, combustib used or stored and location, and such signs that read NC posted with the int smoking.	ons ons shall be adopted and ess than the following be prohibited in any room, ment where flammable le gases, or oxygen is d in any other hazardous area shall be posted with O SMOKING or shall be ernational symbol for no					

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STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION (X3) DATE		(X3) DATE SU	DATE SURVEY	
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER	A. BUILDING <u>03</u> COM		COMPLET	COMPLETED	
155131		155131	B. WINC	G		12/06/20	022
		<u> </u>	<u> </u>	STREET A	ADDRESS, CITY, STATE, ZIP COD	·	
NAME OF PROVIDER OR SUPPLIER					ALUMET AVE		
MUNSTER MED-INN					ER, IN 46321		
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIE			ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIENCY MUST BE PRECEDED BY FULL			REFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ATE (	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION	1	TAG	DEFICIENCY)		DATE
		d at all major entrances,					
		vith language that prohibits					
	smoking shall not						
	(3) Smoking by patients classified as not						
	responsible shall						
	• •	ent of 18.7.4(3) shall not					
	apply where the patient is under direct						
	supervision.	ncombustible material and					
	(5) Ashtrays of noncombustible material and						
	safe design shall be provided in all areas where smoking is permitted.						
	(6) Metal containers with self-closing cover						
	devices into which ashtrays can be emptied						
	shall be readily available to all areas where						
	smoking is permitted.						
	18.7.4, 19.7.4						
		on and interview, the facility	K 074	41 l	Munster Med Inn		12/13/2022
		own Smoking Policy. This			Life Safety Code		-
	deficient practice co	ould affect as many as two			Recertification and State		
	employees who we	re observed smoking outside			Licensure Survey: 12-6-2022	:	
	the facility near the facility 200 kW generator.				K 741		
					Please accept the following as		
	Findings include:				facility's plan of correction. Th	is	
					plan of correction does not		
		on with the Maintenance			constitute an admission of gui	ilt or	
	_	rate Facilities Engineer during			liability by the facility and is		
	_	at 11:43 a.m. on 12/06/22, over			submitted only in response to	the	
		vere strewn on the ground			regulatory requirement.		
		ck near the facility 200 kW			\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\		
	_	nore, a female facility employee			What corrective action will b	е	
	_	rir on the dock smoking a rhere the employee was sitting			accomplished for those residents found to have bee	_	
	_	stic container that had			affected by the deficient	"	
		butts and trash inside. There			practice? Employee was out	side	
	_	cigarette butt in the container			smoking and disposed a cigal		
		an asked if that location was a			in a non-approved can. The fa		
		g area, the Corporate Facilities			is non-smoking. Staff have be	-	
		t Munster Med-Inn was a			Re-educated on facility		
	_	y and employees are to smoke			non-smoking policy. The plast	tic	
	_	ne Maintenance Director			butt container has been remo		

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155131		(X2) MULTIPLE CONSTRUCTION       (X3) DATE SURVEY         A. BUILDING       03       COMPLETED         B. WING       12/06/2022			ETED			
NAME OF P	ROVIDER OR SUPPLIEF				DDRESS, CITY, STATE, ZIP COD			
MUNSTER MED-INN				7935 CALUMET AVE MUNSTER, IN 46321				
(X4) ID PREFIX	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PRE		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION	
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION	TA	AG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE.	DATE	
TAG	poured water inside distinguish the smo plastic container wa facility.  This finding was re	the plastic container to uldering cigarette and the as removed away from the viewed with the Maintenance urporate Facilities Engineer at		NG .	How will the facility identify other residents having the potential to be affected by the same deficient practice has the potential to affect all resident and staff areas near where the employer was smoking.  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? Staff have be re-educated on the facility non-smoking policy. A weekly random audit will be conducted for 3 months to ensure compliance.  How will the corrective action monitored to ensure the deficient practice will not recur and what quality assurance program will put into place? Copy of audit to be reviewed at safety committed meeting for a duration of 3 months. All other deficient practices will be immediately corrected upon occurrence.	e ential ee ity e ne nd en	DATE	

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PRINTED: 12/16/2022 FORM APPROVED OMB NO. 0938-039

AND PLAN OF CORRECTION IDENTIFICATION NUMBER  155131		A. BUILDING B. WING	COMPLETED 12/06/2022				
		STREET ADDRESS, CITY, STATE, ZIP COD 7935 CALUMET AVE MUNSTER, IN 46321					
SUMMARY STATEMENT OF DEFICIENCIE  (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 APPROPRIA' DEFICIENCY)	(X5) COMPLETION DATE			
	ent - Power Cords and						
on Cords strips in a par compone care-relate E) assembled by quaditions of 1 fent care vice REE (e.g., in long-terruse PCREE in e of vicinity tient care roll. It standard ith general re not used of a structurarily are relation of the dand meet 6 (NFPA 98 70), 590.3 (in observation of the left care roll used to ensure 2 of ere not used LSC 19.5.1 9.1. LSC 9 ipment to coal Code, 2015 equires that, cords and care	patient care vicinity are only into of movable delectrical equipment es that have been lified personnel and meet 0.2.3.6. Power strips in cinity may not be used for personal electronics), in care resident rooms that E. Power strips for PCREE oul. 60601-1. Power strips the patient care rooms meet UL 1363. In poms, power strips meet is. All power strips are precautions. Extension das a substitute for fixed re. Extension cords used moved immediately upon purpose for which it was is the conditions of 10.2.4. Phys. 10.2.4 (NFPA 99), 400-8 (NFPA 70), TIA 12-5 (NFPA	K 0920	facility's plan of correction. Thi plan of correction does not	s the			
	OR SUPPLIER INN  SUMMARY S CH DEFICIENCY ULATORY OR 101 cal Equipment of cords strips in a por compone -care-relate E) assemble oled by qualitions of 1 ient care via CREE (e.g., in long-term use PCREE in the of vicinity it ient care related to the poly of a structurarily are rerection of th	IDENTIFICATION NUMBER 155131  OR SUPPLIER  INN  SUMMARY STATEMENT OF DEFICIENCIE CH DEFICIENCY MUST BE PRECEDED BY FULL ULATORY OR LSC IDENTIFYING INFORMATION  101 cal Equipment - Power Cords and cal Equipment - Power Cords and	OR SUPPLIER  IDENTIFICATION NUMBER 155131  OR SUPPLIER  INN  SUMMARY STATEMENT OF DEFICIENCIE CH DEFICIENCY MUST BE PRECEDED BY FULL ULATORY OR LSC IDENTIFYING INFORMATION  101  cal Equipment - Power Cords and con Cords strips in a patient care vicinity are only or components of movable -care-related electrical equipment E) assembles that have been cled by qualified personnel and meet dittions of 10.2.3.6. Power strips in cient care vicinity may not be used for CREE (e.g., personal electronics), in long-term care resident rooms that use PCREE. Power strips for PCREE IL 1363A or UL 60601-1. Power strips -PCREE in the patient care rooms e of vicinity) meet UL 1363. In tient care rooms, power strips meet IL standards. All power strips are ith general precautions. Extension are not used as a substitute for fixed of a structure. Extension cords used arily are removed immediately upon tion of the purpose for which it was d and meets the conditions of 10.2.4. 6 (NFPA 99), 10.2.4 (NFPA 99), 400-8 70), 590.3(D) (NFPA 70), TIA 12-5 on observation and interview, the facility on ensure 2 of 2 extension cords and power ere not used as a substitute for fixed LSC 19.5.1 requires utilities to comply with 9.1. LSC 9.1.2 requires electrical wiring ipment to comply with NFPA 70, National al Code, 2011 Edition. NFPA 70, Article equires that, unless specifically permitted, cords and cables shall not be used as a te for fixed wiring of a structure. LSC 4.5.7 states any building service	OR SUPPLIER INN  SUMMARY STATEMENT OF DEFICIENCIE CHI DEFICIENCY MUST BE PRECEDED BY FULL ULATORY OR LSC IDENTIFYING INFORMATION 101 all Equipment - Power Cords and ion Cords strips in a patient care vicinity are only or components of movable -care-related electrical equipment E) assembles that have been olded by qualified personnel and meet iditions of 10.2.3.6. Power strips in ient care vicinity may not be used for RREE (e.g., personal electronics), in long-term care resident rooms that use PCREE. Power strips for PCREE IL 1363A or UL 60601-1. Power strips -PCREE in the patient care rooms a of vicinity) meet UL 1363. In tient care rooms, power strips meet IL standards. All power strips are ith general precautions. Extension are not used as a substitute for fixed of a structure. Extension cords used arily are removed immediately upon tion of the purpose for which it was d and meets the conditions of 10.2.4. 6 (NFPA 99), 10.2.4 (NFPA 99), 400-8 70), 590.3(D) (NFPA 70), TIA 12-5 on observation and interview, the facility on ensure 2 of 2 extension cords and power ere not used as a substitute for fixed 1. SC 9.1.2 requires electrical wiring ipment to comply with NFPA 70, National all Code, 2011 Edition. NFPA 70, Article requires that, unless specifically permitted, cords and cables shall not be used as a te for fixed wiring of a structure. LSC 4.5.7 states any building service			

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY		
AND PLAN OF CORRECTION IDENTIFIC		IDENTIFICATION NUMBER	A. BU	a. building <u>03</u>		COMPLETED	
155131		B. W	ING		12/06/	2022	
		_		STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF PROVIDER OR SUPPLIER					ALUMET AVE		
MUNSTE	R MED-INN				TER, IN 46321		<u> </u>
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	``	NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI	ATE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	_	installed and approved in					
		l applicable NFPA standards.			What corrective action will be	эе	
	-	tice could affect staff in the			accomplished for those		
	vicinity of the Business Office and Laundry.				residents found to have bee	n	
					affected by the deficient		
	Findings include:				practice? The extension cord		
					power strip were immediately		
		ons with the Maintenance			removed from the laundry roo	om	
	-	orate Facilities Engineer during			and the business office.		
		y from 9:50 a.m. to 12:25 p.m. on					
	12/06/22, the follow	-			How will the facility identify		
	a) a refrigerator was plugged into a power strip in				other residents having the		
	-	ocated in the basement			potential to be affected by the	he	
	b) a coffee pot was	plugged into an extension			same deficient practice? Th	е	
	cord in the Busines	ss Office.			deficient practice has the pote	ential	
	Based on interview	at the time of the			to affect all resident, staff and	1	
	observations, the M	Maintenance Director agreed a			visitor areas near the office's		
	power strip and an	extension cord were being			where the extension cord and	d	
	used as substitutes	for fixed wiring at the			power strip were in use		
	aforementioned loc	eations. The power strip and					
	extension cord wer	re removed at the time of			What measures will the facil	lity	
	observations by the	e Maintenance Director.			take or what systems will th	ıe	
					facility alter to ensure that t		
	This finding was re	eviewed with the Maintenance			problem will be corrected as	n <b>d</b>	
	Director and Corpo	orate Facilties Engineer during			will not recur? Maintenance	<del>,</del>	
	the exit conference				director re-educated office sta	aff on	
					not using extension cords and	d	
	3.1-19(b)				power strips in the facility. A		
					weekly random audit of office	s will	
					be conducted for 3 months t		
					ensure compliance.		
					How will the corrective action	be	
					monitored to ensure the defic	ient	
					practice will not recur and wh	ıat	
					quality assurance program w	ill be	
					put into place? Copy of audit		
					be reviewed at safety commit		
					meeting for a duration of 3		

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#### DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 12/16/2022 FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA  AND PLAN OF CORRECTION IDENTIFICATION NUMBER  155131  NAME OF PROVIDER OR SUPPLIER		IDENTIFICATION NUMBER 155131	A. BUILDING 03 B. WING  STREET ADDRESS, CITY, STATE, ZIP COD			(X3) DATE COMPL 12/06	ETED	
MUNSTER MED-INN				7935 CALUMET AVE MUNSTER, IN 46321				
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)  months. All other deficient practices will be immediately corrected upon occurrence.	TE	(X5) COMPLETION DATE	
					Date of Completion: 12/13/20	22		

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