

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

PRINTED: 03/01/2016
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 _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 02/23/2016
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	
F 000	<p>INITIAL COMMENTS</p> <p>This visit was for with the Investigation of Complaints IN00190985 and IN00191746.</p> <p>This visit was in conjunction with the Post Survey Revisit (PSR) to the Recertification and State Licensure Survey completed on 1/12/16. This visit included the PSR to the Investigations of Complaints IN00188000 and IN00188017 investigated on 1/12/16.</p> <p>Complaint IN00190985-Substantiated. No deficiencies related to the allegation are cited.</p> <p>Complaint IN00191746-Unsubstantiated due to lack of evidence.</p> <p>Survey dates: February 22 & 23, 2016.</p> <p>Facility number: 000056 Provider number: 155131 AIM number: 100289450</p> <p>Census bed type: SNF: 19 SNF/NF: 173 Total: 192</p> <p>Census payor type: Medicare: 41 Medicaid: 103 Other: 48 Total: 192</p> <p>Sample: 7</p> <p>Munster Med Inn was found to be in compliance with 42 CFR Part 483, Subpart B and 410 IAC</p>	F 000			
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.

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

PRINTED: 03/01/2016
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 _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 02/23/2016
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
F 000	Continued From page 1 16.2-3.1 in regard to the Investigation of Complaints IN00190985 and IN00191746. Quality review completed by 26143, on February 28, 2016.	F 000		