DEPARTI	MENT OF HEALTH AN	ID HUMAN SERVICES				FORM APPROVED			
CENTER	S FOR MEDICARE &	MEDICAID SERVICES				OMB NO	D. 0938-0391		
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		155131	B. WING			C 06/10/2021			
NAME OF PROVIDER OR SUPPLIER				S	STREET ADDRESS, CITY, STATE, ZIP CODE				
MUNSTER				7	935 CALUMET AVE				
MUNSTER MED-INN				MUNSTER, IN 46321					
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIZ TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	OULD BE COMPLETION			
F 000	INITIAL COMMENTS		F	000					
	This visit was for the IN00351331, IN0035 ⁷ IN00354464 and IN00								
		31 - Substantiated. No the allegations are cited.							
	-	73 - Substantiated. No the allegations are cited							
	•	52 - Substantiated. No the allegations are cited.							
	Complaint IN00354464 - Substantiated. No deficiencies related to the allegations are o								
	-	74 - Substantiated. No the allegations are cited.							
	Survey dates: June 9	& 10, 2021							
	Facility number: 0000	056							
	Provider number: 155								
	AIM number: 100289	450							
	Census bed type: SNF: 19 SNF/NF: 156 Total: 175								
	Census payor type:								
	Medicare: 36								
	Medicaid: 108								
	Other: 31 Total: 175								
	iulai. 170								
	Munster Med-Inn was	s found to be in compliance							
ABORATORY	DIRECTOR'S OR PROVIDER	SUPPLIER REPRESENTATIVE'S SIGNATU	RE		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.

PRINTED: 06/14/2021

		ID HUMAN SERVICES MEDICAID SERVICES					FORM	D: 06/14/2021 MAPPROVED D. 0938-0391
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		155131	B. WING			_	C 06/10/2021	
NAME OF PROVIDER OR SUPPLIER				S	TREET ADDRESS, CITY, ST	ATE, ZIP CODE		
MUNSTER MED-INN				7935 CALUMET AVE MUNSTER, IN 46321				
			ID	IV		S PLAN OF CORRECTION		(X5)
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		PREF	PREFIX (EACH CORRECTIVE TAG CROSS-REFERENCED		IVE ACTION SHOULD BE SED TO THE APPROPRIATE FICIENCY)		COMPLETION DATE
F 000			1 -					
F 000	F 000 Continued From page 1 with 42 CFR Part 483, Subpart B and 410 IAC		F	000				
	16.2-3.1. in regard to	the Investigation of						
	Complaints IN00351331, IN00351573, IN00354252, IN00354464 and IN00354974.							
	Quality review completed on 6/11/21.							

FORM CMS-2567(02-99) Previous Versions Obsolete

Facility ID: 000056

If continuation sheet Page 2 of 2