

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  03/28/2016
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NAME OF PROVIDER OR SUPPLIER  MUNSTER MED-INN	STREET ADDRESS, CITY, STATE, ZIP CODE 7935 CALUMET AVE MUNSTER, IN 46321
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(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
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K 0000  Bldg. 03	<p>A Post Survey Review (PSR) to the Life Safety Code Recertification and State Licensure Survey conducted on 02/08/16 was conducted by the Indiana State Department of Health in accordance with 42 CFR 483.70(a).</p> <p>Survey Date: 03/28/16</p> <p>Facility Number: 000056 Provider Number: 155131 AIM Number: 100289450</p> <p>At this PSR survey, Munster Med-Inn was found in substantial 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 corridors. Battery operated smoke</p>	K 0000		
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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.

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K 0029 SS=A Bldg. 03	<p>detectors are installed in all resident rooms. The facility has the capacity for 225 and had a census of 202 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>Quality Review by Lex Brashear, Life Safety Code Specialist on 03/28/16</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Hazardous areas are protected in accordance with 8.4. The areas shall be enclosed with a one hour fire-rated barrier, with a 3/4 hour fire-rated door, without windows (in accordance with 8.4). Doors shall be self-closing or automatic closing in accordance with 7.2.1.8. Hazardous areas are protected by a sprinkler system in accordance with 9.7, 18.3.2.1, 18.3.5.1.</p> <p>Based on observation and interview, the facility failed to ensure the set of double doors to 1 of 1 basement linen storage rooms, a soiled linen room, latched into the frame. This deficient practice was not in a resident care area but could affect facility staff.</p> <p>Findings include:</p> <p>Based on observation with the Building Manager on 03/28/16 at 10:25 a.m., the</p>	K 0029	<p>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. What corrective actions will be accomplished for those residents found to have affected by the deficient practice?</p> <p>1. THE BASEMENT LINEN STORAGE DOOR CLOSER HAS BEEN ADJUSTED TO PROPERLY LATCH.</p>	03/29/2016

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	<p>automatic flush bolt striker was hitting the door frame at the top center and prevented the doors from latching. Based on interview at the time of observation, the Building Manager acknowledged the aforementioned condition.</p> <p>This deficiency was cited on 02/08/16. The facility failed to implement a systemic plan of correction to prevent recurrence.</p> <p>3.1-19(b)</p>		<p>How the facility will identify other residenthaving the potential to be affected by the same deficient practice and whatcorrective action will be taken; A FACILITY WALK THRU WAS COMPLETED BY MAINTENANCE MANAGERTO IDENTIFY ANY OTHER AREA NOT MEETING THE REQUIREMENT. NO OTHER DEFICENCIESIDENTIFIED</p> <p>What measures will be put into place orwhat systemic changes will be made to ensure that the deficient practice doesnot recur THE MAINTENANCEMANAGER/DESIGNEE WILL MONITOR DURING THEPREVENTIVE MAINTENANCE ROUNDS. How will the correctiveaction be monitored to ensure the deficient practice will not recur, i.e. whatquality assurance programs will be put into place; MAINTENANCE MANAGER WILL PRESENT THE MONTHLYAUDITS TO THE SAFETY COMMITTEE ON A QUARTERLY BASIS FOR 2 QUARTERS.</p>		