

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 12/01/2011
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NAME OF PROVIDER OR SUPPLIER MUNSTER MED-INN	STREET ADDRESS, CITY, STATE, ZIP CODE 7935 CALUMET AVE MUNSTER, IN46321
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K0000	<p>A Life Safety Code Recertification and State Licensure Survey was conducted by the Indiana State Department of Health in accordance with 42 CFR 483.70(a).</p> <p>Survey Date: 12/01/11</p> <p>Facility Number: 000056 Provider Number: 155131 AIM Number: 100289450</p> <p>Surveyor: Richard D. Schade, Life Safety Code Specialist</p> <p>At this Life Safety Code survey, Munster Med-Inn was found not in 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>	K0000		
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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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K0048 SS=F	<p>This six story facility with a basement was remodeled in 2008 and was determined to be of Type I (332) construction and was fully sprinklered. The facility has a fire alarm system with smoke detection in the corridors and spaces open to the corridors. The facility has a capacity of 225 and had a census of 220 at the time of this survey.</p> <p>Quality Review by Lex Brashear, Life Safety Code Specialist-Medical Surveyor on 12/12/11.</p> <p>The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by the following:</p> <p>There is a written plan for the protection of all patients and for their evacuation in the event of an emergency. 18.7.1.1 Based on record review and interview, the facility failed to provide a written fire plan which</p>	K0048	K048 Submission of this response and Plan of Correction is not legal admission that a deficiency exists, or that a	12/31/2011	

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	<p>includes the procedures for the use of all fire extinguishers for the protection 225 of 225 residents in the event of an emergency. LSC 19.7.2.2 requires a written health care occupancy fire safety plan which shall provide policy and procedures for the following:</p> <ol style="list-style-type: none"> (1) Use of alarms (2) Transmission of alarm to the fire department (3) Response to alarms (4) Isolation of fire (5) Evacuation of immediate area (6) Evacuation of smoke compartment (7) Preparation of floors and building for evacuation (8) Extinguishment of fire <p>This deficient practice could affect all occupants, visitors and staff in the facility in the event of an emergency when the written fire plan should be immediately available.</p> <p>Findings include:</p> <p>Based on record review with the</p>		<p>Statement of Deficiency was correctly cited. Submission of this response is not to be construed as an admission of any deficiency against the facility, the Administrator, or any employees who draft or may be discussed in the in this response and Plan of Correction. In direct response to the five questions listed on the page one of the letter to this facility dated December 14, 2011, the facility offers the following: 1. What corrective actions will be accomplished for those residents found to have been affected by the deficient practice? Upon surveyor identification and notification of the requirement for the Facility Emergency Plan to address the procedures for all of the fire extinguishers including the relationship of the class K extinguisher with the hood suppression system a policy and procedure was developed and included in the Facility Emergency Plan Manual. 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? The facility is confident that development, distribution, and education of said policy will ensure no similar circumstances occur. 3. What measures will be put into place or systematic changes will be made to ensure the deficient practice does not recur. The facility will ensure that all staff be in-serviced</p>		

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K0064 SS=B	<p>maintenance supervisor on 12/01/11 at 12:25 p.m., the written fire plan was found within the Emergency Procedure manual and the maintenance supervisor stated it was last reviewed June 2010. This Emergency Plan is the policy which requires information specific to the facility. The manual did not address the procedures for all of the fire extinguishers and the relationship of the Class K extinguisher with the hood suppression system. The maintenance supervisor stated they were unaware of the requirement of the fire plan, extinguisher policy and procedure.</p> <p>3.1-19(b)</p> <p>Portable fire extinguishers are provided in all health care occupancies in accordance with 9.7.4.1, NFPA 10. 18.3.5.6</p> <p>Based on observation and interview, the facility failed to ensure 1 of 1 portable fire extinguishers in the kitchen was readily identified as a secondary backup to the automatic fire</p>	K0064	<p>on this policy and procedure by December 31, 2011 and annually thereafter. 4. How the corrective action will be monitored to ensure the deficient practice does not recur, i.e. what quality assurance program will be put into place? The Facility Safety Officer will be responsible for ensuring this policy is developed, distributed and that staff are in-serviced on this policy and procedure by December 31, 2011 and annually thereafter. 5. By what date the systematic changes will be completed. December 31, 2011</p> <p>K064</p> <p>Submission of this response and Plan of Correction is not legal admission that a 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 deficiency</p>	12/31/2011	

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	<p>suppression system. NFPA 10, 1998 Edition, 2-3.2.1 requires fire extinguishers to include a conspicuously placed placard which states the automatic fire protection system is to be activated before using the fire extinguisher. This deficient practice affects all staff in and near the kitchen.</p> <p>Findings include:</p> <p>Based on observation with the maintenance supervisor and facility administrator on 12/01/11 at 1:20 p.m., no placard was posted near the Class K extinguisher in the kitchen. The administrator stated they were not aware of the requirement.</p> <p>3.1-19(b)</p>		<p>against the facility, the Administrator, or any employees who draft or may be discussed in the in this response and Plan of Correction.</p> <p>In direct response to the five questions listed on the page one of the letter to this facility dated December 14, 2011, the facility offers the following:</p> <ol style="list-style-type: none"> 1. What corrective actions will be accomplished for those residents found to have been affected by the deficient practice? Upon surveyor identification and notification of the requirement that the class K fire extinguisher located in the kitchen be identified as secondary back up to the automatic fire suppression system a sign was obtained and posted conspicuously in accordance with NFPA 10 1998 Edition, 2-3.2.1. 2. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken. The facility is confident that the conspicuous posting of a sign that states the automatic fire suppression system is to be activated before using the fire extinguisher will ensure that no similar circumstances occur. 3. What measures will be put 		

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K0144 SS=F	Generators are inspected weekly and exercised under load for 30 minutes per month in accordance with NFPA 99. 3.4.4.1. 1. Based on record review and interview, the facility failed to ensure 1 of 1 emergency generators was equipped with a remote manual stop. LSC 7.9.2.3 requires emergency generators providing power to emergency lighting systems shall be installed, tested	K0144	into place or what systematic changes will be made to ensure the deficient practice does not recur. Dietary staff will be in-serviced on the relationship between the automatic fire suppression system the class K fire extinguisher. Additionally, this information will be included in the department specific orientation for all dietary employees. 4. How the corrective actions will be monitored to ensure the deficient practice will not recur. Building Manager will be responsible to ensure the aforementioned sign remains in good condition and conspicuously posted on a monthly basis. This will be documented on the monthly Building Manager round sheets. 5. By what date the systematic changes will be made? December 31, 2011 K144 Submission of this response and Plan of Correction is not legal admission that a 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 deficiency against the facility, the Administrator, or any employees who draft or may be discussed in	12/31/2011	

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	<p>and maintained in accordance with NFPA 110, Standard for Emergency and Standby Power Systems. NFPA 110, 1999 edition, 3-5.5.6 requires Level II installations shall have a remote manual stop station of a type similar to a break-glass station located elsewhere on the premises where the prime mover is located outside the building. NFPA 37, Standard for the Installation and Use of Stationary Combustion Engines and Gas Turbines, 1998 Edition, at 8-2.2(c) requires engines of 100 horsepower or more have provision for the shutting down the engine at the engine and from a remote location. This deficient practice could affect all residents, staff and visitors in the event of an emergency.</p> <p>Findings include:</p> <p>Based on review of the Generator Maintenance records on 12/01/11 at 12:40 p.m. with the maintenance supervisor, there was no</p>		<p>the in this response and Plan of Correction. In direct response to the five questions listed on the page one of the letter to this facility dated December 14, 2011, the facility offers the following: 1. What corrective actions will be accomplished for those residents found to have been affected by the deficient practice. As it relates to observation #1, upon surveyor identification and notification of the requirement to annually test the emergency generator powered lighting systems for not less than 90 minutes, the test was completed as required. As it relates to observation #2, upon surveyor identification and notification of the requirement of the emergency generator to have a remote shut off device this device was scheduled to be installed by January 31, 2011. If this is unable to occur the facility will make the appropriate notification. 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. As it relates to observation #1, the facility is confident that by including the annual function test of the emergency generator powered lighting systems to the current generator testing contract this will ensure no like circumstances will occur. As it relates to observation #2, the facility is confident that installation of the required remote</p>		

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	<p>documentation available which indicated the amount of horsepower the generator provided. The maintenance supervisor stated they did not have a remote shut off device for the emergency generator, furthermore, the maintenance supervisor indicated they were not sure if the generator was 100 horsepower or more and it was installed in 2008 The maintenance supervisor stated at the time of record review they were not aware of the requirement.</p> <p>3.1-19(b)</p> <p>2. Based on record review and interview, the facility failed to ensure emergency task lighting in and around 1 of 1 generator sets was in accordance with NFPA 101, 2000 Edition, Life Safety Code. LSC Section 7.9.3 requires an annual functional test to be conducted on emergency battery lighting systems for not less than 90 minutes. NFPA 110, Section 5-3.1 requires that EPS (Emergency</p>		<p>emergency stop for the emergency generator will ensure no similar circumstances occur.</p> <p>3. What measures will be put into place or what systematic changes will be made to ensure that the deficient practice does not recur. As it relates to observation #1 the facility will maintain documentation of annual testing of the emergency generator powered lighting systems to ensure no similar circumstances recur. As it relates to observation #2 the facility will maintain records of the installation of the required manual remote emergency stop for the emergency generator. 4. How the corrective actions will be monitored to ensure the deficient practice will not recur. As it relates to observation #1, the Building Manager will be responsible for maintaining documentation related to completion of annual testing of the emergency generator powered lighting system. As it relates to observation #2, the Building Manager will maintain documentation of the installation of the required remote emergency stop for the emergency generator. 5. By what date the systematic changes will be completed. Date of Correction: December 31, 2011</p>		

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	<p>Power Supply) equipment locations shall be provided with battery powered emergency lighting. This deficient practice could affect all residents, staff and visitors in the facility.</p> <p>Findings include:</p> <p>Based on record review with the maintenance supervisor on 12/01/11 at 12:55 p.m., the maintenance supervisor acknowledged they had no record of the battery powered lighting at the generator being tested for 90 minutes annually. The maintenance supervisor stated they were not aware of the requirement.</p> <p>3.1-19(b)</p>				