STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155131	A. BUILDING -- B. WING	11/07/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
MUNSTER MED-INN	7935 CALUMET AVE MUNSTER, IN 46321

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E 0000 Bldg. --	An Emergency Preparedness Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.73. Survey Dates: 11/06/24 and 11/07/24 Facility Number: 000056 Provider Number: 155131 AIM Number: 100289450 At this Emergency Preparedness survey, Munster Med-Inn, was found in compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 483.73 The facility has 225 certified beds. At the time of the survey, the census was 155. Quality Review completed on 11/12/24	E 0000	The facility respectfully requests paper compliance for this citation.	
K 0000 Bldg. 03	A Life Safety Code Recertification and State Licensure Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.90(a). Survey Dates: 11/06/24 and 11/07/24 Facility Number: 000056 Provider Number: 155131 AIM Number: 100289450 At this Life Safety Code survey, Munster Med-Inn was found not in compliance with	K 0000	The facility respectfully requests paper compliance for this citation.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Shanika Willhite		11/28/2024

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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	Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.90(a), Life Safety from Fire and the 2012 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19, Existing Health Care Occupancies and 410 IAC 16.2. This six-story facility with a full 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 detectors are installed in all resident rooms. The building is fully protected by a 200-kW diesel-powered generator. The facility has the capacity for 225 and had a census of 155 at the time of this survey. All areas where the residents have customary access were sprinklered and all areas providing facility services were sprinklered. Quality Review completed on 11/12/24			
K 0324 SS=E Bldg. 03	NFPA 101 Cooking Facilities 1) Based on observation and interview, the facility failed to ensure staff were instructed in the use of the UL 300 hood fire suppression system in 1 of 1 kitchen. NFPA 96, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations, Section 10.5.7 states instruction shall be provided to employees regarding the proper use of portable fire extinguishers and the manual activation of fire-extinguishing equipment. Section 11.1.4 states instructions for manually operating the fire extinguishing system shall be posted conspicuously in the kitchen and shall be	K 0324	p="" paraid="1904954766" paraeid="{f67b091b-2f1a-4256-9f1f-b200d1fb8ccd}{161}">Munster Med Inn Life Safety Code Recertification and State Licensure Survey: 11-07-2024 K 324 Cooking Facilities Please accept the following as the facility's plan 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	12/04/2024

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	reviewed with employees by management. This deficient practice could affect kitchen staff. Findings include: Based on observation and interview during tour of the facility with the Maintenance Director and Administrator from 8:30 a.m. to 11:45 a.m. on 11/07/24, the kitchen was provided with a UL 300 hood fire suppression system. Based on interview during tour of the kitchen, Cook #1 was asked what she would do if there was a grease fire underneath the hood. She pointed to the K-class fire extinguisher and stated she would use the fire extinguisher. Based on interview, Cook #1 was asked if using the K-class portable fire extinguisher was the first thing she would do; she replied with "yes." The surveyor pointed to the pull station for the kitchen hood extinguishing system and asked Cook #1 if she knew what the device was, she replied she did not know. Immediately following the interview with the cook, the Administrator advised the food service manager to provide training for the kitchen staff on fire safety and the use of the extinguishing system in the kitchen. 2) Based on observation and interview, the facility failed to provide an approved method for returning cooking appliances to where they were when the kitchen hood extinguishing equipment was designed and installed for 1 of 1 kitchen hood extinguishing systems. NFPA 96 Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations Section 2011 Edition Section 12.1.2.2*Cooking appliances requiring protection shall not be moved, modified, or rearranged without prior re-evaluation of the fire-extinguishing system by the system installer or servicing agent, unless otherwise allowed by		regulatory requirement. ¿ What corrective action will be accomplished for those residents found to have been affected by the deficient practice?¿¿Staff were instructed on the use of the UL 300 hood fire suppression system in . Instructions were provided to employees regarding the use of the UL 300 hood fire suppression system in . The proper use of portable fire extinguisher and the manual activation of fire-extinguishing equipment. Facility placed Waterproof heavy Duty anti-slip tape for high traction tap on floor as markers for an approved method for returning cooking appliances to where they were when the kitchen hood extinguishing equipment was designed and installed for 1 of 1 kitchen hood extinguishing system. How will the facility identify other residents having the potential to be affected by the same deficient practice?¿The deficient practice has the potential to affect Kitchen staff. ¿ 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 director and Food service Manager was educated 11/07/2024 by administrator on in servicing kitchen staff on the use of the UL 300 hood fire suppression system in kitchen.	

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	the design of the fire extinguishing system. Section 12.1.2.3 The fire-extinguishing system shall not require reevaluation where the cooking appliances are moved for the purposes of maintenance and cleaning, provided the appliances are returned to approved design location prior to cooking operations, and any disconnected fire-extinguishing system nozzles attached to the appliances are reconnected in accordance with the manufacturer's listed design manual. Section 12.1.2.3.1 An approved method shall be provided that will ensure that the appliance is returned to an approved design location. This deficient practice could affect kitchen staff. The findings include: Based on observation and interview during tour of the facility with the Maintenance Director and Administrator from 8:30 a.m. to 11:45 a.m. on 11/07/24, cooking appliances including a gas burner stove and oven, 2 flat-top grills, and 2 gas ovens were located under the hood in 1 of 1 kitchen were not provided with an approved method that would ensure that the appliances were returned to an approved design location after they had been moved for maintenance and cleaning. Based on interview with the Maintenance Director, he was not aware of any method or procedure in place but stated he would correct the deficiency soon. These findings were reviewed with the Maintenance Director and the Administrator at the exit conference. 3.1-19(b)		The proper use of portable fire extinguisher and the manual activation of fire-extinguishing equipment. Kitchen staff educated on 11/08/2024 by Maintenance Director and Food Service Manager the use of the UL 300 hood fire suppression system in kitchen. The proper use of portable fire extinguisher and the manual activation of fire-extinguishing equipment. Kitchen staff also educated 11/08/2024 by Maintenance Director and Food Service Manager on the return placement of cooking appliance to where they were when kitchen hood extinguishing was designed and installed. Maintenance department and Food Service Manager educated on 11/07/2024 by administrator on approved method for returning cooking appliances to where they were when the kitchen hood extinguishing equipment was designed and installed for 1 of 1 kitchen hood extinguishing system. 5 Days a week for 4 weeks then weekly for the remaining 6 an audit will be conducted for placement of Waterproof heavy Duty anti-slip tape for high traction tap on floor as markers for an approved method for returning cooking appliances to where they were when the kitchen hood extinguishing equipment was	

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			designed and installed for 1 of 1 kitchen hood extinguishing system to ensure compliance. 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 be reviewed at safety committee meeting for a duration of 6 months.¿ All other deficient practices will be immediately corrected upon occurrence. ¿ ¿ Date of Completion: 12/4/2024	
K 0353 SS=F Bldg. 03	NFPA 101 Sprinkler System - Maintenance and Testing Based on record review and interview, the facility failed to maintain 1 of 1 wet sprinkler system in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems, Section 5.3.4. Section 5.3.4 states that the freezing point of solutions in antifreeze shall be tested annually by measuring the specific gravity with a hydrometer or refractometer and adjusting the solution if necessary. This deficient practice could affect all residents, staff and visitors. Findings include: Based on record review and interview with the Maintenance Director and Administrator on 11/06/24 from 9:40 a.m. to 1:10 p.m., page 7 of the Report of Inspection/Test dated 07/16/24 from the sprinkler vendor, indicated that the antifreeze solution measured at -5 degrees Fahrenheit. In	K 0353	Munster Med Inn Life Safety Code Recertification and State Licensure Survey: 11-07-2024 K (353) Please accept the following as the facility's plan 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?¿ Vendor scheduled for 12/04/2024 to check wet sprinkler system to added antifreeze solution measuring at -10 degrees Fahrenheit per regulation. How will the facility identify other residents	12/04/2024

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	accordance with NFPA 25 Figure A.5.3.4.1 the solution should be adjusted to -10 degrees Fahrenheit. Based on interview at the time of record review, the Maintenance Director and Administrator were not aware they had an antifreeze system. This finding was reviewed with the Maintenance Director and the Administrator at the exit conference. 3.1-19(b)		having the potential to be affected by the same deficient practice?¿ ¿The deficient practice has the potential to affect all staff, residents, and visitors in the event of a fire. ¿ 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 was educated on11/08/2024 by Vice president of operation about reading the inspection reports thoroughly and knowing how to identify issues on reports. Education included the wet sprinkler system inspection, testing and maintenance of water-based fire protection systems with focus on antifreeze solution state required of -10 degrees Fahrenheit. ¿ ¿ 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?¿¿A copy of work order will be reviewed at committee meeting to ensure compliance. ¿ Date of Completion: 12/04/2024	
K 0363 SS=E Bldg. 03	NFPA 101 Corridor - Doors Based on observation and interview, the facility failed to maintain protection of corridor doors on 2 floors of the 6 story facility in accordance of LSC 19.3.6.3. Section 19.3.6.3.5 states Doors shall be provided with a means for keeping the door closed that is acceptable to the authority having	K 0363	Munster Med Inn Life Safety Code Recertification and State Licensure Survey: 11-7-2024 K 363 Corridor Doors: Please accept the following as the facility's plan of	12/04/2024

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	jurisdiction, and the following requirements also shall apply: (1) The device used shall be capable of keeping the door fully closed if a force of 5 lbf (22 N) is applied at the latch edge of the door. (2) Roller latches shall be prohibited on corridor doors in buildings not fully protected by an approved This deficient practice could affect residents, staff and visitors on 2 of 6 floors. Findings include: Based on observation and interview during tour of the facility with the Maintenance Director and Administrator from 8:30 a.m. to 11:45 a.m. on 11/07/24, 1. The clean linen closet door on the West side of the South end of the 3rd floor corridor failed to close and latch. Based on observation, paper towels filled the latch hole in the door frame preventing the door from latching. Based on interview and observation, this was confirmed by the Maintenance Director when he removed the paper towel from the latch hole. The door properly latched after the paper towel was removed. 2. The storage closet door on the West side of the 2nd floor across from the nurses' station failed to close and latch. Based on interview and observation, the Maintenance director confirmed the door did not latch and stated the door was equipped with a door handle but no latching mechanism. This finding was reviewed with the Maintenance Director and the Administrator at the exit conference. 3.1-19(b)		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?¿¿Clean Linen closet door on the west side of the south end of the 3 floor corridor tested to close and latched. The storage closet door on the west side of the 2 floor across from the nurse station has latching mechanism and was tested. Both doors now latch properly.¿ How will the facility identify other residents having the potential to be affected by the same deficient practice?¿The deficient practice has the potential to affect residents on and 3 floor. 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 were educated on the need for doors to latch properly on 11/21/2024 by the administration.¿ audit 5 days a week for 4 weeks and weekly for the remaining 6 will be conducted on 5 random doors to ensure proper latching.¿ How will the corrective action be monitored to ensure the deficient practice will not recur and what quality assurance program will be put into	

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			place?¿¿Copy of audit will be reviewed at safety committee meeting for a duration of 6 months.¿ All other deficient practices will be immediately corrected upon occurrence. ¿ Date of Completion: 12/04/2024	