STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155131	A. BUILDING **03** B. WING _____	**07/25/2024**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MUNSTER MED-INN	**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
K 000	INITIAL COMMENTS A Life Safety Code Preoccupancy Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.90(a). The basement employee break room and storage room was removed from licensed space to create a dialysis unit. Survey Date: 07/25/2024 Facility Number: 000056 Provider Number: 155131 AIM Number: 100289450 At this Life Safety Code Preoccupancy Survey, Munster-Med Inn was found in compliance with 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.	K 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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155131	A. BUILDING **03** B. WING _____	**07/25/2024**

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K 000	Continued From page 1 Quality Review completed on 07/26/24	K 000		