PRINTED: 08/12/2021 FORM APPROVED OMB NO. 0938-0391

STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MU	JLTIPLE CO	NSTRUCTION	(X3) DATE	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BU	ILDING		COMPL	ETED
		155469	B. WI	NG	<u> </u>	07/14	/2021
				CTDEET A	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIEI	R					
0,00,00	T LIODADT				49TH AVE		
CASA OI	F HOBART			повак	RT, IN 46342		
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPR	BIATE	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)	J/(12	DATE
E 0000							
Bldg							
_	An Emergency Pre-	paredness Survey was	E 00	000			
	conducted by the Indiana Department of Health in accordance with 42 CFR 483.73.						
	Survey Date: 07/14	4/21					
	Facility Number: (000366					
	Provider Number:						
	AIM Number: 100288900						
	Allyl Number: 100288900						
	At this Emergency Preparedness survey, Casa of						
	Hobart was found in compliance with Emergency						
	Preparedness Requirements for Medicare and						
	Medicaid Participating Providers and Suppliers,						
	_	ting Providers and Suppliers,					
	42 CFR 483.73						
	TI C 114 1 126	0 4'6 11 1 444 4'					
	-	8 certified beds. At the time					
	of the survey, the c	ensus was 84.					
	0 11: D	1 . 1 . 07/20/21					
	Quality Review coi	mpleted on 07/28/21					
K 0000							
K 0000							
Dida 04							
Bldg. 01	A I :fo C-f-t- C 1	Description of 1 State	77.0	200			
	· ·	e Recertification and State	K 00)00			
		vas conducted by the Indiana					
	_	lth in accordance with 42					
	CFR 483.90(a).						
	g 5	4/01					
	Survey Date: 07/14	4/21					
		200266					
	Facility Number: (
	Provider Number:						
	AIM Number: 100	0288900					
		Code survey, Casa of Hobart					
	was found not in co	ompliance with Requirements					
	<u> </u>						l
LABORATOR	RY DIRECTOR'S OR PRO	VIDER/SUPPLIER REPRESENTATIVE'S SI	IGNATURE		TITLE		(X6) DATE

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds 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.

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

Facility ID:

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	OF CORRECTION	IDENTIFICATION NUMBER:		ULTIPLE CO JILDING	01	(X3) DATE COMPL	
11112 12111	or commercial	155469	B. W		01	07/14/	
				STREET A	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	ROVIDER OR SUPPLIER				49TH AVE		
CASA OF	HOBART			HOBAR	T, IN 46342		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	·	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	.TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
		Medicare/Medicaid, 42 CFR Life Safety from Fire, and the					
		National Fire Protection					
	Association (NFPA) 101, Life Safety Code (LSC), Chapter 19, Existing Health Care						
	Occupancies and 41	0 IAC 16.2.					
	This facility was sur	rveyed as three separate					
	buildings due to the construction types of three						
	sections of the build	0					
		951 as a house is of Type V					
	(000) construction and is fully sprinklered; Building 0202 renovated in 1972 and 1999 was						
	determined to be of Type II (111) construction						
		red; and Building 0302 built					
		ined to be of Type V (111)					
		lly sprinklered, encompasses					
		east sections of the facility. fire alarm system with					
		the corridors and spaces					
		s. The facility has wired					
		all resident sleeping rooms.					
	•	apacity of 138 and a census of					
	84 at the time of this	s survey.					
	All areas where resi	dents have customary access					
		All areas providing facility					
	services were sprink	klered.					
	Quality Review con	npleted on 07/28/21					
K 0222	NFPA 101						
SS=E	Egress Doors						
Bldg. 01	Egress Doors						
		d means of egress shall					
		rith a latch or a lock that f a tool or key from the					
	•	s using one of the following					
	special locking arr						
	CLINICAL NEEDS	OR SECURITY THREAT					

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	OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA	· ′		ONSTRUCTION	(X3) DATE	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:		UILDING	01	COMPL	
		155469	B. W	ING		07/14/	/2021
NAME OF F	ROVIDER OR SUPPLIEF	3		STREET A	ADDRESS, CITY, STATE, ZIP CODE		
TWINE OF I	ROVIDER OR SOLVEIE			4410 W	49TH AVE		
CASA OF	HOBART			HOBAR	RT, IN 46342		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	ADOLUDEDIO N. IN OF CODDECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI	ATE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)	AIE	DATE
	LOCKING						
	Where special loc	king arrangements for the					
	clinical security needs of the patient are						
	used, only one loo	cking device shall be					
	permitted on each	n door and provisions shall					
	be made for the ra	apid removal of occupants					
	by: remote contro	l of locks; keying of all					
	-	ied by staff at all times; or					
	other such reliable	e means available to the					
	staff at all times.						
18.2.2.2.5.1, 18.2.2.2.6, 19.2.2.2.5.1,							
19.2.2.2.6							
SPECIAL NEEDS LOCKING							
	ARRANGEMENTS						
	Where special locking arrangements for the						
	-	e patient are used, all of					
		curity Locking requirements					
		addition, the locks must be					
		at fail safely so as to					
		of power to the device; the ed by a supervised					
		er system and the locked					
		d by a complete smoke					
		(or is constantly monitored					
		cation within the locked					
		the sprinkler and detection					
		nged to unlock the doors					
	upon activation.	.904 10 41110011 4110 40010					
	18.2.2.2.5.2, 19.2	.2.2.5.2. TIA 12-4					
	DELAYED-EGRE						
	ARRANGEMENT						
	Approved, listed of	lelayed-egress locking					
		in accordance with					
	•	permitted on door					
	assemblies servin	ig low and ordinary hazard					
	contents in building	ngs protected throughout by					
	an approved, sup	ervised automatic fire					
	detection system	or an approved, supervised					
	automatic sprinkle	er system.					
	18.2.2.2.4, 19.2.2	.2.4					
1			- 1				1

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Event ID:

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STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MU	JLTIPLE CO	ONSTRUCTION	(X3) DATE S	URVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BU	ILDING	01	COMPLE	TED
		155469	B. WI	NG		07/14/2	2021
				STREET	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIE	R			/ 49TH AVE		
CASA OI	F HOBART				RT, IN 46342		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ATE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
		ROLLED EGRESS					
	LOCKING ARRAI						
		d Egress Door assemblies					
		lance with 7.2.1.6.2 shall					
	be permitted.	0.4					
	18.2.2.2.4, 19.2.2	.2.4 BY EXIT ACCESS					
	LOCKING ARRANGEMENTS Elevator lobby exit access door locking in						
	accordance with 7.2.1.6.3 shall be permitted						
	on door assemblies in buildings protected						
		approved, supervised					
	automatic fire detection system and an						
	approved, supervised automatic sprinkler						
	system.	·					
	18.2.2.2.4, 19.2.2	.2.4					
	Based on observati	on and interview, the facility	K 0222		K222 NFPA 101 EGRESS DO	OR	08/06/2021
	failed to ensure the	delayed egress locking					
	arrangements were	installed in accordance with			The facility requests paper		
		2.2.4 in 1 of 7 exits. Section			compliance for this citation.		
		at doors within a required					
	_	all not be equipped with a			This Plan of Correction is the		
		quires the use of a tool or			center's credible allegation of		
		s side, unless otherwise			compliance.		
	_	19.2.2.2.4 (2) states that					
		ts complying with 7.2.1.6.1 LSC 7.2.1.6.1(3) states an			Preparation and/or execution		
	_	shall release the lock in the			this plan of correction does no	ot	
	•	within 15 seconds, or 30			constitute admission or		
	_	roved by the authority having			agreement by the provider of	the	
		pplication of a force to the			truth of the facts alleged or		
	-	ired in 7.2.1.5.10 under all of			conclusions set forth in the		
	the following condi				statement of deficiencies. The	-	
	_	not be required to exceed 15			plan of correction is prepared		
	lbf (67 N).				and/or executed solely because		
	` '	not be required to be			it is required by the provisions	5 07	
		ed for more than 3 seconds.			federal and state law.		
		f the release process shall			4) Image distance the second		
		signal in the vicinity of the			Immediate actions take for those residents identified		
	door opening.				ioi triose residents identified	۷.	

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	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155469	(X2) MULTIP A. BUILDIN B. WING	LE CONSTRUCTION NG <u>01</u>	(X3) DATE SURVEY COMPLETED 07/14/2021
	PROVIDER OR SUPPLIEF	2	44	REET ADDRESS, CITY, STATE, ZIP CODE 10 W 49TH AVE DBART, IN 46342	E
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAC	CROSS-REFERENCED TO THE APPR	D BE COMPLETION
	(d) Once the lock happlication of force relocking shall be be deficient practice of service hall of the findings include: During a tour of the Administrator, Assis Maintenance Direct when the 15 second pushed in the employers to release the there was no audiblicating to push until opened in 15 second release after 15 second door code was performed by the Administrator and agreed the door lock second delay egress. This finding was read the Administrator, Assis applications of the second delay egress.	as been released by the to the releasing device, by manual means only. This build affect all staff within the facility. The facility with the distant Administrator and tor on 07/14/21 at 1:19 p.m., I delayed egress door was been elock was not initiated, and the signal. The door had an signal alarm sounds. Door can be designal. The door would not bonds after multiple attempts. The door, and the after the code was entered. The time of observation, and Maintenance Director k did not release with the 15 st.		 Employee entrance signage stating that door wafter 15 seconds was rem Access to egress will be be code posted by keypad. Twere no residents cited in to this regulation. 2) How the facility identification other residents: Staff employed at the community have the potent be affected by the alleged deficient practice. 3) Measures put into place system changes: The Maintenance Department will inspect exweekly to ensure proper functioning and will docum the Preventative Maintenate Worksheet. The Maintenate Worksheet. The Maintenate Director will be re-educated the Preventative Maintenated t	e door will open loved. by use of There regard fied fied fied ce/ kit doors nent on ance eld on ance eld on ance tions QAPI ox 4 and
				monthly thereafter, to mor	nitor

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	OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		ULTIPLE CO JILDING	onstruction 01	(X3) DATE : COMPL		
		155469	B. W	ING	<u> </u>	07/14/		
	ROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 4410 W 49TH AVE HOBART, IN 46342					
(X4) ID PREFIX TAG	(EACH DEFICIEN	FATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE	
K 0353 SS=E Bldg. 01	Sprinkler System - Automatic sprinkle are inspected, test accordance with N Inspection, Testing Water-based Fire Records of system inspection and tes secure location an a) Date sprinkler b) Who provided c) Water system Provide in REMAR coverage for any r automatic sprinkle 9.7.5, 9.7.7, 9.7.8, Based on observation failed to maintain the	supply source RKS information on non-required or partial r system.	K 0	353	compliance. The results of these aud will be reviewed in Quality Assurance Meeting monthly for months or until 100% compliant is achieved. The QA Committ will identify any trends or patternand make recommendations to revise the plan of correction as indicated. 5) Date of compliance: 8/6/2021 K 353 NFPA 101 SPRINKLER SYSTEM – MAINTENANCE ATESTING	or 6 nce ee erns o s	08/06/2021	

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY				
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BU	JILDING	01	COMPLETED
		155469	B. W	ING		07/14/2021
				CTDEET /	ADDRESS, CITY, STATE, ZIP CODE	
NAME OF P	ROVIDER OR SUPPLIER	2				
040405	LIODADT				49TH AVE	
CASA OF	HOBART			HOBAR	RT, IN 46342	
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	DDOVIDED'S DI AN OF CODDECTION	(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA'	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)	DATE
	Section 3.3.5.4 defi	nes a smooth ceiling as a				
	continuous ceiling f	free from significant			The facility requests paper	
	irregularities, lumps, or indentations. The ceiling traps hot air and gases around the sprinkler and				compliance for this citation.	
					•	
	-	to operate at a specified			This Plan of Correction is the	
	-	n 8.5.4.1.1 states the distance			center's credible allegation of	
	-	er deflector and the ceiling			compliance.	
	above shall be selected based on the type of					
		pe of construction. This			Preparation and/or execution of	of
	deficient practice could affect 18 residents,				this plan of correction does no	
	staff, and visitors in				constitute admission or	
	Mechanical room by	-				do a
					agreement by the provider of t	ne
	Findings include:				truth of the facts alleged or	
	Č				conclusions set forth in the	
	Based on observation	on with the Administrator,			statement of deficiencies. The)
		rator and Maintenance			plan of correction is prepared	
		our of the facility from 12:22			and/or executed solely becaus	ie e
	_	n 07/14/21, the following was			it is	
		nical room by resident room				
	71:	•			1) Immediate actions take	
	a) suspended ceiling	g tile missing leaving 12 inch			for those residents identified	:
		to the ceiling grid above near				
	the wall opposite th				· Ceiling tiles in mechanic	
		space around a pipe			room near room 71 were repla	
	penetrating the susp				and penetrations were sealed.	
		space around over 8 cables			One-inch annular space aroun	d
		pended ceiling near the door.			the pipes and annular space	
	The room was equip	pped with two pendant			around 8 cables penetrating th	
	sprinkler installed o	on the suspended ceiling.			suspended ceiling were sealed	
	Based on interview	-			There were no residents cited	in
	observations, the A	dministrator and Maintenance			regard to this regulation.	
	Director acknowled	ged the missing ceiling tile				
		rations in the aforementioned			2) How the facility identified	∌d
	room.				other residents:	
	This finding was re	viewed with the			· Staff, Visitors and	
	Administrator, Assi	stant Administrator and			Residents have the potential to	l l
		for at the exit conference.			affected by the alleged deficien	nt
					practice.	
			1			1

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	OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDING	01	COMPLETED	
		155469	B. WING		07/14/2021	
NAME OF P	ROVIDER OR SUPPLIER			T ADDRESS, CITY, STATE, ZIP CODE		
CASA OF	- HOBART			W 49TH AVE ART, IN 46342		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	ID			(X5)
PREFIX	•	CY MUST BE PRECEDED BY FULL	PREFIX	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRO	O BE COM	MPLETION
TAG	REGULATORY OR 3.1-19(b)	LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)		DATE
	3.1-19(0)			3) Measures put into plac System changes:	ee/	
				Inspection of susper ceiling will be completed wand documented on the Preventative Maintenance Worksheet Log by the Maintenance Department. The Maintenance Department. The Maintenance Department will be re-educe the Preventative Maintena Program by the Executive Director/designee by 8/6/2 The Maintenance Dis responsible for compliance. How the corrective actions will be monitored tool will be utilized weekly monthly thereafter, to mon compliance.	cated on nace 1. irector nace. I: IAPI x 4 and itor	
				will be reviewed in Quality Assurance Meeting month months or until 100% com is achieved. The QA Com will identify any trends or p and make recommendation	pliance mittee patterns	
				revise the plan of correction indicated 5. Compliance Date:	n as	
				8/6/21		
				and make recommendation revise the plan of correction indicated 5. Compliance Date:	ns to	
				5. Compliance Date:		

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STATEMEN	IT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE SU	IRVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BU	JILDING	01	COMPLET	TED
		155469	B. W	NG		07/14/20	021
				STREET A	ADDRESS, CITY, STATE, ZIP CODE	<u> </u>	
NAME OF P	PROVIDER OR SUPPLIER				/ 49TH AVE		
CASA OF	HOBART			HOBART, IN 46342			
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE (COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
K 0372	NFPA 101		İ				•
SS=E	Subdivision of Bui	lding Spaces - Smoke					
Bldg. 01	Barrie						
-	Subdivision of Building Spaces - Smoke Barrier Construction 2012 EXISTING						
	Smoke barriers sh	nall be constructed to a					
	1/2-hour fire resistance rating per 8.5.						
	Smoke barriers sh	nall be permitted to					
	terminate at an at	rium wall. Smoke dampers					
are not required in duct penetrations in fully ducted HVAC systems where an approved							
		• •					
		s installed for smoke					
	compartments adjacent to the smoke barrier.						
	19.3.7.3, 8.6.7.1(1	•					
	Describe any med system in REMAR	hanical smoke control RKS.					
	Based on observation	on and interview, the facility	K 0	372	K372 NFPA 101 SUBDIVISIO	N (08/06/2021
	failed to ensure the	penetrations caused by the			OF BUILDING SPACES –		
	passage of wire and	or conduit through 4 of 6			SMOKE BARRIER		
	smoke barrier walls	were protected to maintain					
	the smoke resistanc	e of each smoke barrier.			The facility requests paper		
	LSC Section 19.3.7	.5 requires smoke barriers to			compliance for this citation.		
		ecordance with LSC Section					
		minimum ½ hour fire			This Plan of Correction is the		
		s deficient practice could			center's credible allegation of		
	affect staff and at le	east 34 residents and staff.			compliance.		
	Findings include:				Preparation and/or execution of		
	D11	and a side of the Admits of th			this plan of correction does no	t	
		ons with the Administrator, rator and Maintenance			constitute admission or		
					agreement by the provider of t	he	
		1 during a tour of the facility lowing unsealed penetration			truth of the facts alleged or		
	was discovered:	lowing unscaled penetration			conclusions set forth in the		
		o inch gap in the smoke			statement of deficiencies. The	,	
					plan of correction is prepared		
barrier above the suspended ceiling by reside room 1.		spended centing by resident			and/or executed solely becaus	se	
		at the time of observation,			it is required by the provisions	of	
		nd Maintenance Director			federal and state law.		
	l		1		İ	1	

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	OF CORRECTION IDENTIFICATION NUMBER: 155469	A. BUILDING B. WING	01	COMPLETED 07/14/2021
	PROVIDER OR SUPPLIER F HOBART	4410 V	ADDRESS, CITY, STATE, ZIP CODE V 49TH AVE RT, IN 46342	
(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 CORRECTIC (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROI DEFICIENCY)	ON (X5) BE COMPLETION DATE
TAG	REGULATORY OR LSC IDENTIFYING INFORMATION) acknowledged the aforementioned condition and provided the measurements. This finding was reviewed with the Administrator, Assistant Administrator and Maintenance Director at the exit conference. 3.1-19(b)	TAG	1) Immediate actions to for those residents identifications and cited in regard to this regulary. The penetrations aborder resident room has been repaired. 2) How the facility identification other residents: Residents, staff and have the potential to be affectly the alleged deficient practices. Besidents of the potential to be affectly the alleged deficient practices. Outside contractors of educated, prior to completing services on the building, aborder fire wall penetrations. Maintenance Director/designations will inspect for penetrations to job completion. The Maintenance Director designation of the penetrations	aken ied: ents ation. ove om 1 ed visitors ected ctice. e/ will be ng oout s. The gnee s prior rector ce.
			An Environmental Que tool will be utilized monthly monitor compliance with sn barrier walls. The results of these will be reviewed in Quality Assurance Meeting monthly.	to noke audits

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	OF CORRECTION	IDENTIFICATION NUMBER: 155469 A. BUILDING 01 B. WING		COMPLETED 07/14/2021	
NAME OF F	PROVIDER OR SUPPLIER			ADDRESS, CITY, STATE, ZIP CODE	
CASA OF	HOBART			V 49TH AVE RT, IN 46342	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	(X5) COMPLETION DATE
K 0918 SS=F Bldg. 01	Electrical Systems System Maintenan The generator or a source and associon of supplying service 10-second criterion monthly test, a pro- annually confirm the safety and critical is and testing of the a switches are perfor NFPA 110. Generator sets are exercised under lo year in 20-40 day is once every 36 mon hours. Scheduled include a complete automatic or manu- loads, and are con- personnel. Mainten energy power soun accordance with N circuit breakers are a program for peric components is est	- Essential Electric Syste - Essential Electric ace and Testing other alternate power ated equipment is capable be within 10 seconds. If the in is not met during the acess shall be provided to his capability for the life branches. Maintenance generator and transfer action accordance with a inspected weekly, and 30 minutes 12 times a antervals, and exercised onths for 4 continuous test under load conditions a simulated cold start and all transfer of all EES ducted by competent cance and testing of stored aces (Type 3 EES) are in FPA 111. Main and feeder a inspected annually, and odically exercising the ablished according to irements. Written records		months or until 100% compliar is achieved. The QA Committe will identify any trends or patter and make recommendations to revise the plan of correction as indicated 5) Date of compliance:	ee rns o

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STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MU	LTIPLE CO	ONSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	01	COMPL	ETED
		155469	B. WIN	IG		07/14/	/2021
				CTDEET A	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIE	R					
0.00.00	FLIODADT				/ 49TH AVE		
CASA OI	F HOBART			HOBAR	RT, IN 46342		
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	NCY MUST BE PRECEDED BY FULL	F	REFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	of maintenance a	nd testing are maintained					
	and readily availa	ible. EES electrical panels					
	and circuits are m	narked, readily identifiable,					
	and separate from	n normal power circuits.					
	Minimizing the po	ssibility of damage of the					
	emergency powe	r source is a design					
	consideration for						
		(NFPA 99), NFPA 110,					
	NFPA 111, 700.1	•					
		view and interview, the	K 09	18	K918 NFPA 101 ELECTRICAL		08/06/2021
	1	aintain a complete written			SYSTEM- ESSENTIAL		
		generator load testing for 8 of			ELECTRIC SYSTEM		
		and ensured the generator ran					
		napter 6.4.4.1.1.4(a) of 2012			The facility requests paper		
	_	monthly testing of the			compliance for this citation.		
	-	he emergency electrical			This Discost Commontions in the		
		cordance with NFPA 110, the			This Plan of Correction is the		
		gency and Standby Powers			center's credible allegation of		
		3. NFPA 110 8.4.2 requires ts in service to be exercised at			compliance.		
	-	, for a minimum of 30			l _	_	
		4.4.2 of NFPA 99 requires a			Preparation and/or execution of		
	_	rspection, performance,			this plan of correction does no	t	
		and repairs for the generator			constitute admission or		
		ntained and available for			agreement by the provider of t	he	
		uthority having jurisdiction.			truth of the facts alleged or		
		tice could affect all			conclusions set forth in the		
	occupants.				statement of deficiencies. The	•	
	1				plan of correction is prepared		
	Findings include:				and/or executed solely becaus		
					it is required by the provisions	of	
	Based on records re	eview with the Administrator			federal and state law.		
	and Maintenance D	Director on 07/14/21 at 12:00					
	p.m., no documenta	ation was available for review			1) Immediate actions take		
	to show the diesel	generator set in service was			for those residents identified	l :	
	exercised at least o	nce monthly for the months					
of November, December of 2020, January,				The Monthly generator I	load		
	February, March, A	April, May, June of 2021.			tested was completed on		
		iew at the time of record			0.11		
	review, the Admini	istrator acknowledged the			2) How the facility identified		

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	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155469	(X2) MULTII A. BUILDI B. WING	PLE CONSTRUCTION ING 01	(X3) DATE SURVEY COMPLETED 07/14/2021				
	PROVIDER OR SUPPLIEI F HOBART	2	44	STREET ADDRESS, CITY, STATE, ZIP CODE 4410 W 49TH AVE HOBART, IN 46342					
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION)	ID PREI TA	FIX PROVIDER'S PLAN OF CORRECT FIX (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPRO	D BE COMPLETION				
IAU	monthly generator during the aforeme were no further doc Maintenance Directhe facility for two testing before he was This finding was re Administrator, Ass	tests were not conducted nitioned months and there ruments to review. The tor has only been employed at weeks and can not speak to as hired.		other residents: Residents, staff and have the potential to be af by the alleged deficient processing the state of the potential to be af by the alleged deficient processing the state of the processing the state of the processing	I visitors fected actice. place/ and ator load ment on ance ad on ance 21.				
				An Environmental Control will be utilized monthly monitor compliance. The results of these will be reviewed in Quality Assurance Meeting month months or until 100% complist is achieved. The QA Company will identify any trends or pland make recommendation revise the plan of corrections.	y to e audits lly for 6 pliance mittee patterns ns to				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		ľ	ULTIPLE CC ЛLDING	01	COMPL				
155469		B. W		01	07/14/				
	PROVIDER OR SUPPLIER		<u> </u>	STREET ADDRESS, CITY, STATE, ZIP CODE 4410 W 49TH AVE HOBART, IN 46342					
(X4) ID PREFIX TAG	(EACH DEFICIEN	FATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY) indicated	ATE	(X5) COMPLETION DATE		
					5) Date of compliance: 8/6/21				
K 0923 SS=E Bldg. 01	Storag Gas Equipment - O Storage Greater than or equipment - O Storage locations and ventilated in a and 5.1.3.3.3. >300 but <3,000 c Storage locations enclosure or within space of non- or ling construction, with that can be secure stored with flamma from combustibles sprinklered) or encononcombustible cominimum 1/2 hr. fill Less than or equal in a single smoke cylinders available patient care areas of less than or equal not required to be Cylinders must be as specified in 11. A precautionary si on each door or garoom, where the sa minimum "CAUT STORED WITHIN	are outdoors in an an enclosed interior mited- combustible door (or gates outdoors) and. Oxidizing gases are not ables, and are separated by 20 feet (5 feet if closed in a cabinet of construction having a re protection rating. It to 300 cubic feet compartment, individual for immediate use in with an aggregate volume and to 300 cubic feet are stored in an enclosure. handled with precautions 6.2. In general gate in the storage ign includes the wording as a storage ign includes the wor							

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY			
AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BU	A. BUILDING 01		COMPLETED			
	155469		B. W	B. WING			07/14/2021	
				CTREET	ADDRESS SITY STATE ZIR CODE			
NAME OF PROVIDER OR SUPPLIER					ADDRESS, CITY, STATE, ZIP CODE			
l					49TH AVE			
CASA OF	HOBART			HOBART, IN 46342				
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION	
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)	'- I	DATE	
	order of which the	ey are received from the						
	supplier. Empty of	cylinders are segregated						
	from full cylinders	. When facility employs						
		gral pressure gauge, a						
	threshold pressure considered empty is established. Empty cylinders are marked to avoid confusion. Cylinders stored in the open							
	are protected fron	· ·						
	11.3.1, 11.3.2, 11	.3.3, 11.3.4, 11.6.5 (NFPA						
	99)							
	Based on observation	on and interview, the facility	K 0923		K923 NFPA GAS EQUIPMENT –		08/06/2021	
	failed to ensure 1 or	f 1 cylinders of			CYLINDER AND CONTRAINER			
	nonflammable gases such as oxygen were properly secured from falling. NFPA 99, Health				STORAGE			
	Care Facilities Cod	e, 2012 Edition, Section			The facility requests paper			
	11.3.2 states storage	e for nonflammable gases			compliance for this citation.			
	greater than 8.5 cub	pic meters (300 cubic feet)						
	but less than 85 cub	pic meters (3000 cubic feet)			This Plan of Correction is the			
	shall comply with 1	1.3.2.1 through 11.3.2.3.			center's credible allegation of			
	NFPA 99, Section 1	11.3.2.6 states cylinder or			compliance.			
	container restraints	shall comply with 11.6.2.3.						
	Section 11.6.2.3(11) states freestanding			Preparation and/or execution of	of		
	cylinders shall be properly chained or supported in a proper cylinder stand or cart. This deficient practice could affect 28 residents and staff in the vicinity of the main nurses station.				this plan of correction does no			
					constitute admission or			
					agreement by the provider of t	the		
					truth of the facts alleged or			
					conclusions set forth in the			
	Findings include:				statement of deficiencies. The	_		
					plan of correction is prepared			
		on with the Administrator,			and/or executed solely because			
		rator, and Maintenance			it is required by the provisions			
	1	our of the facility from 12:22			federal and state law.	01		
	1	n 07/14/21, one 'E' type			reuerai anu state iaw.			
		ras standing upright on the			1) Immediate actions take	<u> </u>		
		tween two offices in the main			1) Immediate actions take for those residents identified			
		was not properly chained or			ioi tilose residents identified			
		er cylinder stand or cart.			· Oxygen Cylinder was			
		at the time of observation,			removed from main nurse's			
		cknowledged the 'E' type			station.			
	oxygen cylinders in	the aforementioned location			อเสมปา.			

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AND PLAN OF CORRECTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155469		A. BUI B. WIN	LDING	01	COMPLETED 07/14/2021			
	PROVIDER OR SUPPLIEI	R		STREET ADDRESS, CITY, STATE, ZIP CODE 4410 W 49TH AVE HOBART, IN 46342				
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	P	ID REFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	(X5) COMPLETION DATE		
	proper cylinder star This finding was re Administrator, Ass				2) How the facility identified other residents: Staff have the potent be affected by the alleged deficient practice. 3) Measures put into place/System changes:	ial to		
					the proper storage of oxyger cylinders by maintenance Director/designee by 8/6/21. An audit tool will be developed to ensure proper storage of oxygen cylinders. Observation will be complete three times weekly for 4 weethen 2x weekly for 6 months deficiencies will be corrected immediately.	ed ks Any		
					 The Maintenance Dire or designee is responsible for compliance. How the corrective actions will be monitored: The results of these are will be reviewed in Quality Assurance Meeting monthly months or until 100% complisis achieved. The QA Comm will identify any trends or pat and make recommendations 	udits for 6 ance ittee terns		

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	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01		(X3) DATE SURVEY COMPLETED			
	155469	B. WING	07/14/2021				
NAME OF PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 4410 W 49TH AVE				
HOBART		HOBART, IN 46342					
SUMMARY ST	TATEMENT OF DEFICIENCIES	ID	DROVIDED'S DI AN OF CODDECTION		(X5)		
(EACH DEFICIENCE	CY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE	rc	COMPLETION		
REGULATORY OR	LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	I C	DATE		
			revise the plan of correction as indicated	3			
			5) Date of compliance:				
			· 8/6/21				
I	PROVIDER OR SUPPLIER HOBART SUMMARY ST (EACH DEFICIENCE)	DESTRICTION IDENTIFICATION NUMBER: 155469 ROVIDER OR SUPPLIER	TO F CORRECTION IDENTIFICATION NUMBER: 155469 ROVIDER OR SUPPLIER HOBART SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL A. BUILDING B. WING STREET A 4410 W HOBAR	A. BUILDING 01 B. WING STREET ADDRESS, CITY, STATE, ZIP CODE 4410 W 49TH AVE HOBART SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) B. WING STREET ADDRESS, CITY, STATE, ZIP CODE 4410 W 49TH AVE HOBART, IN 46342 ID PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) TAG revise the plan of correction as indicated 5) Date of compliance:	A. BUILDING B. WING A. BUILDING B. WING OT OT/14/ STREET ADDRESS, CITY, STATE, ZIP CODE 4410 W 49TH AVE HOBART SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) TAG Deficiency PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) revise the plan of correction as indicated 5) Date of compliance:		

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