

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 03/18/2025  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>155469</b>		(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b>  <b>03/12/2025</b>	
NAME OF PROVIDER OR SUPPLIER  <b>CASA OF HOBART</b>				STREET ADDRESS, CITY, STATE, ZIP CODE <b>4410 W 49TH AVE</b> <b>HOBART, IN 46342</b>			
(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
F 000	<p>INITIAL COMMENTS</p> <p>This visit was for the Investigation of Complaints IN00453904 and IN00454281.</p> <p>This visit was in conjunction with the Post Survey Revisit (PSR) to the Recertification and State Licensure Survey and the Investigation of Complaints IN00450254, IN00450652 and IN00451800 completed on January 29, 2025.</p> <p>Complaint IN00453904 - No deficiencies related to the allegations are cited.</p> <p>Complaint IN00454281 - No deficiencies related to the allegations are cited.</p> <p>Complaint IN00450254 - Corrected.</p> <p>Complaint IN00450652 - Corrected.</p> <p>Complaint IN00451800 - Corrected.</p> <p>Survey dates: March 11 and 12, 2025</p> <p>Facility number: 000366 Provider number: 155469 AIM number: 100288900</p> <p>Census Bed Type: SNF/NF: 87 Total: 87</p> <p>Census Payor Type: Medicare: 6 Medicaid: 72 Other: 9 Total: 87</p>			F 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.

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 03/18/2025  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>155469</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>03/12/2025</b>
NAME OF PROVIDER OR SUPPLIER  <b>CASA OF HOBART</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>4410 W 49TH AVE</b> <b>HOBART, IN 46342</b>		
(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	
F 000	Continued From page 1  Casa of Hobart was found to be in compliance with 42 CFR Part 483, Subpart B and 410 IAC 16.2-3.1 in regard to the Investigation of Complaints IN00453904 and IN00454281.  Quality review completed on 3/14/25.	F 000			