STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155469	A. BUILDING -- B. WING	03/03/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
CASA OF HOBART	4410 W 49TH AVE HOBART, IN 46342

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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
E 0000 Bldg. --	An Emergency Preparedness Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.73. Survey Date: 03/03/2025 Facility Number: 000366 Provider Number: 155469 AIM Number: 100288900 At this Emergency Preparedness survey, Casa of Hobart was found not in compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 483.73 The facility has 138 certified beds. At the time of the survey, the census was 91. Quality Review completed on 03/05/25	E 0000		
E 0004 SS=F Bldg. --	403.748(a), 416.54(a), 418.113(a), 441.1 Develop EP Plan, Review and Update Annually Based on record review and interview, the facility failed to review and update the Emergency Preparedness Plan (EPP) at least annually in accordance with 42 CFR 483.73(a). This deficient practice could affect all residents, staff and visitors. Findings include: Based on record review and interview with the Maintenance Director from 8:35 a.m. to 11:30 a.m. on 03/03/25, documentation provided showed the EPP was reviewed on 01/03/2024, and not in the	E 0004	**What corrective action will be accomplished for those residents found to have been affected by the deficient practice?** The annual review of the Emergency Preparedness Plan has been completed by the Maintenance Director and Administrator. **How will the facility identify other residents having the potential to be affected by the same deficient practice?** This	04/01/2025

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Zachary Glassburn	Administrator	03/17/2025

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155469	A. BUILDING -- B. WING	03/03/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
CASA OF HOBART	4410 W 49TH AVE HOBART, IN 46342

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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
	last 12 months. Based on interview during record review, the Maintenance Director stated that no other documentation of a more recent review or update was available. Based on interview with the Administrator at the time of exit, he stated he became administrator of the facility six weeks ago and had not reviewed the EPP since starting. This finding was reviewed with the Administrator and Maintenance Director at the exit conference.		deficient practice could affect all residents, staff, and visitors in the facility. **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 was educated to ensure annual review is completed at the beginning of each year. **How will the corrective action be monitored to ensure the practice, i.e., what quality assurance program will be put into place?** Emergency Preparedness plan will be reviewed and updated as needed in the first quarter Safety Committee meeting annually. Any deficient practice will be corrected upon occurrence.	
E 0013 SS=F Bldg. --	403.748(b), 416.54(b), 418.113(b), 441.1 Development of EP Policies and Procedures Based on record review and interview, the facility failed to review and update the Emergency Preparedness Plan (EPP) Policies and Procedures at least annually in accordance with 42 CFR 483.73(b). The LTC facility must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least annually. This deficient practice could affect all residents, staff and visitors.	E 0013	**What corrective action will be accomplished for those residents found to have been affected by the deficient practice?** The annual review of Emergency Preparedness Plan Policies and Procedures was completed by Maintenance Director and Administrator. **How will the facility identify other residents having the potential to be affected by the same deficient practice?** This deficient practice could affect all	04/01/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155469	A. BUILDING -- B. WING	03/03/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
CASA OF HOBART	4410 W 49TH AVE HOBART, IN 46342

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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
	Findings include: Based on record review and interview with the Maintenance Director from 8:35 a.m. to 11:30 a.m. on 03/03/25, documentation provided showed the EPP Policies and Procedures was reviewed on 01/03/2024, and not in the last 12 months. Based on interview during record review, the Maintenance Director stated no other documentation of a more recent review or update was available. Based on interview with the Administrator at the time of exit, he stated he became administrator of the facility six weeks ago and had not reviewed the EPP since starting. This finding was reviewed with the Administrator and Maintenance Director at the exit conference.		residents, staff, and visitors in the facility. **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 was educated to ensure annual review is completed at the beginning of each year. **How will the corrective action be monitored to ensure the practice, i.e., what quality assurance program will be put into place?** Emergency Preparedness Plan Policies and Procedures will be reviewed and updated as needed in the first quarter Safety Committee meeting annually. Any deficient practice will be corrected upon occurrence.	
E 0029 SS=F Bldg. --	403.748(c), 416.54(c), 418.113(c), 441.1 Development of Communication Plan Based on record review and interview, the facility failed to review and update the Emergency Preparedness Communication Plan at least annually in accordance with 42 CFR 483.73(c). The facility must develop and maintain an emergency preparedness communication plan that complies with Federal, State and local laws and must be reviewed and updated at least annually for LTC facilities. This deficient practice could affect all residents, staff and visitors. Findings include: Based on record review and interview with the Maintenance Director from 8:35 a.m. to 11:30 a.m.	E 0029	**What corrective action will be accomplished for those residents found to have been affected by the deficient practice?** The Emergency Preparedness Communication Plan was reviewed and updated. **How will the facility identify other residents having the potential to be affected by the same deficient practice?** This deficient practice could affect all residents, staff, and visitors in the facility. **What measures will the facility**	04/01/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155469	A. BUILDING -- B. WING	03/03/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
CASA OF HOBART	4410 W 49TH AVE HOBART, IN 46342

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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
	on 03/03/25, documentation provided showed the EPP Communication Plan was reviewed on 01/03/2024, and not in the last 12 months. Based on interview during record review, the Maintenance Director stated no other documentation of a more recent review or update was available. Based on interview with the Administrator at the time of exit, he stated he became administrator of the facility six weeks ago and had not reviewed the EPP since starting. This finding was reviewed with the Administrator and Maintenance Director at the exit conference.		**take or what systems will the facility alter to ensure that the problem will be corrected and will not recur?** Maintenance Director was educated to ensure annual review is completed at the beginning of each year. **How will the corrective action be monitored to ensure the practice, i.e., what quality assurance program will be put into place?** Emergency Preparedness Communication Plan will be reviewed and updated as needed in the first quarter Safety Committee meeting annually. Any deficient practice will be corrected upon occurrence.	
E 0036 SS=F Bldg. --	403.748(d), 416.54(d), 418.113(d), 441.1 EP Training and Testing Based on record review and interview, the facility failed to review and update the Emergency Preparedness Training and Testing Program at least annually in accordance with 42 CFR 483.73(d). The LTC facility must develop and maintain an emergency preparedness training and testing program that is based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, policies and procedures at paragraph (b) of this section, and the communication plan at paragraph (c) of this section. The training and testing program must be reviewed and updated at least annually. This deficient practice could affect all residents, staff and visitors. Findings include:	E 0036	**What corrective action will be accomplished for those residents found to have been affected by the deficient practice?** The annual review of Emergency Preparedness Plan Testing and Training Program was completed by the Maintenance Director and Administrator. **How will the facility identify other residents having the potential to be affected by the same deficient practice?** This deficient practice could affect all residents, staff, and visitors in the facility. **What measures will the facility take or what systems will the**	04/01/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155469	A. BUILDING -- B. WING	03/03/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
CASA OF HOBART	4410 W 49TH AVE HOBART, IN 46342

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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
	Based on record review and interview with the Maintenance Director from 8:35 a.m. to 11:30 a.m. on 03/03/25, documentation provided showed the EPP Testing and Training Program was reviewed on 01/03/2024, and not in the last 12 months. Based on interview during record review, the Maintenance Director stated no other documentation of a more recent review or update was available. Based on interview with the Administrator at the time of exit, he stated he became administrator of the facility six weeks ago and had not reviewed the EPP since starting. This finding was reviewed with the Administrator and Maintenance Director at the exit conference.		**facility alter to ensure that the problem will be corrected and will not recur?** Maintenance Director was educated to ensure annual review is completed at the beginning of each year. **How will the corrective action be monitored to ensure the practice, i.e., what quality assurance program will be put into place?** Emergency Preparedness Plan Testing and Training Program will be reviewed and updated as needed in the first quarter Safety Committee meeting annually. Any deficient practice will be corrected upon occurrence.	
E 0039 SS=F Bldg. --	403.748(d)(2), 416.54(d)(2), 418.113(d)(EP Testing Requirements Based on record review and interview, the facility failed to conduct exercises to test the emergency plan at least twice per year, including unannounced staff drills using the emergency procedures. The LTC facility must do the following: (i) Participate in an annual full-scale exercise that is community-based; or a. When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise. b. If the LTC facility experiences an actual natural or man-made emergency that requires activation of the emergency plan, the LTC facility is exempt from engaging its next required full-scale in a community-based or individual, facility-based full-scale functional exercise for 1 year following the onset of the actual event. (ii) Conduct an additional exercise that may include, but is not limited to the following:	E 0039	**What corrective action will be accomplished for those residents found to have been affected by the deficient practice?** An Emergency Exercise will be completed by Maintenance Director and Administrator. **How will the facility identify other residents having the potential to be affected by the same deficient practice?** This deficient practice could affect all residents, staff, and visitors in the facility. **What measures will the facility take or what systems will the facility alter to ensure that the problem will be corrected and**	04/01/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155469	A. BUILDING -- B. WING	03/03/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
CASA OF HOBART	4410 W 49TH AVE HOBART, IN 46342

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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
	a. A second full-scale exercise that is community-based or an individual, facility-based functional exercise. b. A mock disaster drill; or c. A tabletop exercise or workshop that is led by a facilitator that includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the LTC facility's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the LTC facility's emergency plan, as needed in accordance with 42 CFR 483.73(d)(2). This deficient practice could affect all residents, staff and visitors. Findings include: Based on record review and interview with the Maintenance Director from 8:35 a.m. to 11:30 a.m. on 03/03/25, the facility provided documentation of a functional facility-based exercise, however, the facility was unable to provide documentation of a second exercise conducted during the past 12 month period. At time of record review the Maintenance Director stated no other exercises were conducted. This finding was reviewed with the Administrator and Maintenance Director at the exit conference.		**will not recur?** Maintenance Director was educated to ensure 2 exercises are completed each year. Administrator and/or designee will audit quarterly to ensure emergency preparedness exercises are completed. **How will the corrective action be monitored to ensure the practice, i.e., what quality assurance program will be put into place?** Emergency Preparedness Exercises will be reviewed in the quarterly Safety Committee meetings. Any deficient practice will be corrected upon occurrence.	
K 0000 Bldg. 01	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).	K 0000		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155469	A. BUILDING 01 B. WING	03/03/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
CASA OF HOBART	4410 W 49TH AVE HOBART, IN 46342

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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
	Survey Date: 03/03/2025 Facility Number: 000366 Provider Number: 155469 AIM Number: 100288900 At this Life Safety Code survey, Casa of Hobart was found not 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 facility was surveyed as three separate buildings due to the construction types of three sections of the building: Building 0102 originally built in 1951 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 and is now sprinklered; and Building 0302 built in 1999 was determined to be of Type V (111) construction and fully sprinklered, encompasses the north and southeast sections of the facility. The facility has one fire alarm system with smoke detection in the corridors and spaces open to the corridors. The facility has hard-wired smoke detectors in all resident sleeping rooms. The facility has a capacity of 138 and a census of 91 at the time of this survey. All areas where residents have customary access were sprinklered. All areas providing facility services were sprinklered. Quality Review completed on 03/05/25			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155469	A. BUILDING 01 B. WING	03/03/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
CASA OF HOBART	4410 W 49TH AVE HOBART, IN 46342

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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 0271 SS=E Bldg. 01	NFPA 101 Discharge from Exits Based on observation and interview, the facility failed to ensure exits in 1 of 5 smoke compartments were marked with directional signage. LSC 7.7.3.2 states the exit discharge shall be arranged and marked to make clear the direction of egress travel from the exit discharge to a public way. This deficient practice could affect residents, staff and visitors in 1 of 5 smoke compartments. Findings include: Based on observation and interview with the Administrator and Maintenance Director from 8:35 a.m. to 11:30 a.m. on 03/03/25, no directional signage was provided in the dining room located outside of the memory care unit in an unoccupied wing of the facility. Two doors in the dining room were marked as not an exit; however, no signage was located in the dining room that led to the corridor that led to the exit of the building. Based on interview at the time of the observation, the Maintenance Director acknowledged the dining room did not have directional signage and stated he would remove the signs indicating the doors in the dining room were not exits. When asked how someone would know where to exit the dining room, he acknowledged a directional exit sign would need to be installed in the dining room. This finding was reviewed with the Administrator and Maintenance Director during the exit conference. 3.1-19(b)	K 0271	**What corrective action will be accomplished for those residents found to have been affected by the deficient practice?** Maintenance Director removed sticker signage from the exit door and installed an exit sign above the door on 3/13/2025. **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 all staff, residents and visitors requiring an exit from this dining room area. **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?** Permanent exit sign was installed on 3/13/2025 and will be checked monthly by maintenance director or designee to ensure compliance. **How will the corrective action be monitored to ensure the practice, i.e., what quality assurance program will be put into place?** Exit Sign audit documentation will be reviewed in the quarterly Safety Committee meeting. Any deficient practice will be corrected upon occurrence.	04/01/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155469	A. BUILDING 01 B. WING	03/03/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
CASA OF HOBART	4410 W 49TH AVE HOBART, IN 46342

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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 0324 SS=E Bldg. 01	NFPA 101 Cooking Facilities 1.) Based on record review and interview, the facility failed to provide documentation to show 1 of 1 kitchen exhaust systems was inspected. NFPA 96, 2011 Edition, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations, Section 11.4 states the entire exhaust system shall be inspected for grease buildup by a properly trained, qualified, and certified person(s) acceptable to the authority having jurisdiction and in accordance with Table 11.4. Table 11.4, Schedule for Inspection for Grease Buildup, requires systems serving moderate volume cooking operations shall be inspected semiannually. NFPA 96, 11.6.1 states, upon inspection, if the exhaust system is found to be contaminated with deposits from grease laden vapors, the contaminated portions of the exhaust system shall be cleaned by a properly trained, qualified, and certified person(s) acceptable to the authority having jurisdiction. Hoods, grease removal devices, fans, ducts, and other appurtenances shall be cleaned to remove combustible contaminants prior to surfaces becoming heavily contaminated with grease or oily sludge. After the exhaust system is cleaned, it shall not be coated with powder or other substance. When an exhaust cleaning service is used, a certificate showing the name of the servicing company, the name of the person performing the work, and the date of inspection or cleaning shall be maintained on the premises. This deficient practice affects kitchen staff. Findings include: Based on record review and interview with the Maintenance Director from 8:35 a.m. to 11:30 a.m.	K 0324	**What corrective action will be accomplished for those residents found to have been affected by the deficient practice?** Kitchen Exhaust System cleaning was completed in July 2024 and documentation was obtained from service provider. Maintenance Director placed markings on floor in the kitchen to ensure appliances are in approved design location under the kitchen hood 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 all staff, residents and visitors in the event a fire event occurs. **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 in-serviced dietary staff on fire suppression system, proper placement of equipment and will include dietary staff on monthly fire drills. Maintenance Director to ensure markings are on the floor in the kitchen and equipment in approved design location under the kitchen hood system. Maintenance Director will audit equipment placement weekly.	04/01/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155469	A. BUILDING 01 B. WING	03/03/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
CASA OF HOBART	4410 W 49TH AVE HOBART, IN 46342

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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
	on 03/03/25, the facility failed to provide documentation of an annual or semiannual kitchen exhaust system inspection or cleaning. Based on interview at the time of record review, the Maintenance Director was not aware of a kitchen exhaust cleaning or inspection; however, during the exit conference the Maintenance Director stated he had the documentation but was not able to locate it in his binder. The Maintenance Director contacted the dietary manager and asked if she had the documentation; however, she was not able to provide any documentation to show a kitchen exhaust hood cleaning or inspection had been completed. 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 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		**How will the corrective action be monitored to ensure the practice, i.e., what quality assurance program will be put into place?** Kitchen Exhaust System documentation will be reviewed in the quarterly Safety Committee meeting. Fire Drill documentation will be reviewed in the monthly QAPI meeting. Any deficient practice will be corrected upon occurrence.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155469	A. BUILDING 01 B. WING	03/03/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
CASA OF HOBART	4410 W 49TH AVE HOBART, IN 46342

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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
	appliance is returned to an approved design location. This deficient practice could affect kitchen staff. Findings include: Based on record review and interview with the Maintenance Director from 8:35 a.m. to 11:30 a.m. on 03/03/25, cooking appliances including a gas 6-burner stove and oven with a flat-top grill was 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 an approved method for returning cooking appliances to where they were when the kitchen hood extinguishing equipment was designed and installed. 3.) 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 reviewed with employees by management. This deficient practice could affect kitchen staff only. Findings include: Based on observation and interview with the			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155469	A. BUILDING 01 B. WING	03/03/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
CASA OF HOBART	4410 W 49TH AVE HOBART, IN 46342

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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
	Maintenance Director from 8:35 a.m. to 11:30 a.m. on 03/03/25, the kitchen was provided with a UL 300 hood fire suppression system. Based on interview during tour of the kitchen, a cook and the dietary manager was asked what they would do if there was a grease fire underneath the hood. They failed to mention activating the fire suppression system or using the K-Class fire extinguisher and stated they had not received training. Based on interview with the Maintenance Director at the time of the kitchen tour, he stated he had never conducted any training with the kitchen staff and never conducted a fire drill with kitchen staff. These findings were reviewed with the Administrator and Maintenance Director at the exit conference. 3.1-19(b)			
K 0353 SS=F Bldg. 01	NFPA 101 Sprinkler System - Maintenance and Testing 1.) Based on record review and interview, the facility failed to provide written documentation or other evidence the sprinkler system components had been inspected and tested for 3 of 4 quarters. LSC 4.6.12.1 requires any device, equipment or system required for compliance with this Code be maintained in accordance with applicable NFPA requirements. Sprinkler systems shall be properly maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. NFPA 25, 4.3.1 requires records shall be made for all inspections, tests, and maintenance of the system components and shall be made available to the authority having jurisdiction upon request. 4.3.2 requires that records shall indicate the procedure	K 0353	**What corrective action will be accomplished for those residents found to have been affected by the deficient practice?** The annual back flow test was completed on 3/12/2025 and the quarterly sprinkler test was completed on 3/12/2025 and is up to date for the current calendar year of 2025. **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 all staff, residents and	04/01/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155469	A. BUILDING 01 B. WING	03/03/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
CASA OF HOBART	4410 W 49TH AVE HOBART, IN 46342

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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
	performed (e.g., inspection, test, or maintenance), the organization that performed the work, the results, and the date. NFPA 25, 5.2.5 requires that waterflow alarm devices shall be inspected quarterly to verify they are free of physical damage. NFPA 25, 5.3.3.1 requires the mechanical waterflow alarm devices including, but not limited to, water motor gongs, shall be tested quarterly. 5.3.3.2 requires vane-type and pressure switch-type waterflow alarm devices shall be tested semiannually. This deficient practice could affect all residents, staff, and visitors. Findings include: Based on record review and interview with the Maintenance Director from 8:35 a.m. to 11:30 a.m. on 03/03/25, there was no quarterly sprinkler system inspection reports available for the first quarter of 2024 or 2025, or the third or fourth quarters of 2024. Based on interview at the time of record review, the Maintenance Director acknowledged there was no documentation available to show inspections had been completed since an annual inspection conducted on 04/04/2024. During the survey, the Maintenance Director and the Administrator attempted to contact a corporate representative that they believed had received the reports, they also attempted to contact the contractor that performed to inspections. The Maintenance Director and Administrator stated the inspections had been completed; however, they were not able to provide any documentation to show the inspections had been completed. Based on interview at the time of record review, both the Maintenance Director and the Administrator stated they had changed sprinkler service contractors.		visitors in the event a fire event occurs. **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?** The Maintenance Director was re-educated on ensuring quarterly sprinkler tests and the annual back flow test is completed in a timely manner. Quarterly audit will be completed by administrator or designee to ensure compliance. **How will the corrective action be monitored to ensure the practice, i.e., what quality assurance program will be put into place?** Sprinkler Inspection and back flow documentation will be reviewed in the quarterly Safety Committee meeting. Any deficient practice will be corrected upon occurrence.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155469	A. BUILDING 01 B. WING	03/03/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
CASA OF HOBART	4410 W 49TH AVE HOBART, IN 46342

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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
	2.) Based on record review, observation and interview, the facility failed ensure 1 of 1 backflow prevention device in the sprinkler system piping was tested annually in accordance with NFPA 25. NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems, 2011 Edition, Section 13.6.2.1 states all backflow preventers installed in fire protection system piping shall be tested annually by conducting a forward flow test of the system at the designed flow rate, including hose stream demand, where hydrants or inside hose stations are located downstream of the backflow preventer. This deficient practice could affect all residents, staff and visitors. Findings include: Based on record review and interview with the Maintenance Director from 8:35 a.m. to 11:30 a.m. on 03/03/25, there was no record of an annual backflow preventer available for review over the past year on the backflow preventer device for the sprinkler system water supply. Based on observation with the Maintenance Director from 11:33 a.m. to 2:32 p.m. on 03/03/25, a backflow preventer was observed on the sprinkler system. During the survey, the Maintenance Director and the Administrator attempted to contact a corporate representative that they believed had received the reports, they also attempted to contact the contractor that performed to inspections. The Maintenance Director and Administrator stated the inspections had been completed; however, they were not able to provide any documentation to show the inspections had been completed. Based on interview at the time of record review, both the Maintenance Director and the Administrator stated they had changed sprinkler service			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155469	A. BUILDING 01 B. WING	03/03/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
CASA OF HOBART	4410 W 49TH AVE HOBART, IN 46342

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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
	contractors. These findings were reviewed with the Administrator and Maintenance Director at the exit conference. 3.1-19(b)			
K 0511 SS=E Bldg. 01	NFPA 101 Utilities - Gas and Electric Based on observation and interview, the facility failed to ensure 1 of 1 wet locations in the pantry located on the memory care unit were provided with ground fault circuit interrupter (GFCI) protection against electric shock. LSC 19.5.1.1 requires utilities comply with Section 9.1. LSC 9.1.2 requires electrical wiring and equipment to comply with NFPA 70, National Electrical Code. NFPA 70, NEC 2011 Edition at 210.8 Ground-Fault Circuit-Interrupter Protection for Personnel, states, ground-fault circuit-interruption for personnel shall be provided as required in 210.8(A) through (C). The ground-fault circuit-interrupter shall be installed in a readily accessible location. (B) Other Than Dwelling Units. All 125-volt, single-phase, 15- and 20-ampere receptacles installed in the locations specified in 210.8(B)(1) through (8) shall have ground-fault circuit-interrupter protection for personnel. (1) Bathrooms (2) Kitchens (3) Rooftops (4) Outdoors Exception No. 1 to (3) and (4): Receptacles that are not readily accessible and are supplied by a branch circuit dedicated to electric snow-melting, deicing, or pipeline and vessel heating equipment shall be permitted to be installed in accordance	K 0511	**What corrective action will be accomplished for those residents found to have been affected by the deficient practice?** The GFCI outlet was replaced by the Maintenance Director. **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 all staff, residents and visitors. **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?** GFCI outlets will be tested monthly by the Maintenance Director to ensure proper functioning. A monthly audit of GFCI outlet testing logs will be conducted by the administrator or designee to ensure compliance. **How will the corrective action be monitored to ensure the practice, i.e., what quality**	04/01/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155469	A. BUILDING 01 B. WING	03/03/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
CASA OF HOBART	4410 W 49TH AVE HOBART, IN 46342

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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
	with 426.28 or 427.22, as applicable. Exception No. 2 to (4): In industrial establishments only, where the conditions of maintenance and supervision ensure that only qualified personnel are involved, an assured equipment grounding conductor program as specified in 590.6(B)(2) shall be permitted for only those receptacle outlets used to supply equipment that would create a greater hazard if power is interrupted or having a design that is not compatible with GFCI protection. (5) Sinks - where receptacles are installed within 1.8 m (6 ft.) of the outside edge of the sink. Exception No. 1 to (5): In industrial laboratories, receptacles used to supply equipment where removal of power would introduce a greater hazard shall be permitted to be installed without GFCI protection. Exception No. 2 to (5): For receptacles located in patient bed locations of general care or critical care areas of health care facilities other than those covered under 210.8(B)(1), GFCI protection shall not be required. (6) Indoor wet locations (7) Locker rooms with associated showering facilities (8) Garages, service bays, and similar areas where electrical diagnostic equipment, electrical hand tools, or portable lighting equipment are to be used. NFPA 70, 517-20 Wet Locations, requires all receptacles and fixed equipment within the area of the wet location to have ground-fault circuit interrupter (GFCI) protection. Note: Moisture can reduce the contact resistance of the body, and electrical insulation is more subject to failure. This deficient practice could affect staff in the memory care unit pantry.		**assurance program will be put into place?** GFCI outlet testing documentation will be reviewed in the quarterly Safety Committee meeting. Any deficient practice will be corrected upon occurrence.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155469	A. BUILDING 01 B. WING	03/03/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
CASA OF HOBART	4410 W 49TH AVE HOBART, IN 46342

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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
	Findings include: Based on observation and interview with the Maintenance Director from 8:35 a.m. to 11:30 a.m. on 03/03/25, there was an electric receptacle 42 inches from the sink in the pantry in the memory care unit. The electric receptacle was a ground fault circuit interrupters (GFCI) type, but failed to interrupt electrical power when tested with a GFCI tester. This was confirmed by the Maintenance Director at the time of observation. This finding was reviewed with the Administrator at the exit conference. 3.1-19(b)			
K 0712 SS=F Bldg. 01	NFPA 101 Fire Drills Based on record review and interview, the facility failed to conduct 4 of 12 fire drills in 4 of 4 quarters during the most recent twelve month time period. LSC 19.7.1.6 requires drills to be conducted quarterly on each shift under varied conditions. This deficient practice affects all staff and residents. Findings include: Based on record review and interview with the Maintenance Director from 8:35 a.m. to 11:30 a.m. on 03/03/25, the facility was unable to provide documentation of fire drills for: 1.) second shift in the first quarter of 2024 or 2025, 2.) third shift in the second quarter of 2024, 3.) first shift in the third quarter, 4.) first shift in the fourth quarter of 2024. Based on interview at the time of record review, the Maintenance Director stated he was informed	K 0712	**What corrective action will be accomplished for those residents found to have been affected by the deficient practice?** A second shift fire drill was conducted on 3/13/2025 for compliance in the first quarter of 2025. Fire drills to be conducted monthly and across all three shifts each quarter going forward. **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 all staff, residents and visitors in the event a fire event occurs. **What measures will the facility take or what systems will the**	04/01/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155469	A. BUILDING 01 B. WING	03/03/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
CASA OF HOBART	4410 W 49TH AVE HOBART, IN 46342

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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
	of when to conduct fire drills but was not familiar with the requirements. This finding was reviewed with the Administrator and Maintenance Director at the exit conference. 3.1-19(b) 3.1-51(c)		**facility alter to ensure that the problem will be corrected and will not recur?** The Maintenance Director was re-educated on the requirements to conduct fire drills on every shift, every quarter. A monthly audit of fire drill logs will be conducted by the administrator or designee to ensure compliance. **How will the corrective action be monitored to ensure the practice, i.e., what quality assurance program will be put into place?** Fire Drill documentation will be reviewed in the monthly QAPI meeting. Any deficient practice will be corrected upon occurrence.	