		The second secon	770)	201700001700017017	G. 22 1.0.0,00 307	
		X1) PROVIDER/SUPPLIER/CLIA		CONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING		COMPLETED	
		155469	B. WING		03/03/2025	
	PROVIDER OR SUPPLIER	2	4410 \	FADDRESS, CITY, STATE, ZIP COD W 49TH AVE IRT, IN 46342		
(X4) ID	(X4) ID SUMMARY STATEMENT OF DEFICIENCIE		ID		(X5)	
PREFIX			PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	COMPLETION	
		ICY MUST BE PRECEDED BY FULL		CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE	
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY.	DATE	
E 0000						
Bldg	conducted by the In accordance with 42 Survey Date: 03/03 Facility Number: 00 Provider Number: 1 AIM Number: 1002 At this Emergency Hobart was found in Emergency Prepare	72025 00366 155469 288900 Preparedness survey, Casa of the incompliance with edness Requirements for caid Participating Providers	E 0000			
E 0004 SS=F Bldg	The facility has 138 certified beds. At the time of the survey, the census was 91. Quality Review completed on 03/05/25 403.748(a), 416.54(a), 418.113(a), 441.1 Develop EP Plan, Review and Update					
-	Based on record rev failed to review and Preparedness Plan (accordance with 42 practice could affect visitors. Findings include: Based on record rev Maintenance Direct on 03/03/25, docum	view and interview, the facility I update the Emergency (EPP) at least annually in CFR 483.73(a). This deficient at all residents, staff and view and interview with the tor from 8:35 a.m. to 11:30 a.m. mentation provided showed the on 01/03/2024, and not in the	E 0004	What corrective action will to accomplished for those residents found to have been affected by the deficient practice? The annual review the Emergency Preparedness Plan has been completed by Maintenance Director and Administrator. How will the facility identify other residents having the potential to be affected by the same deficient practice? The	n of sthe	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

(X6) DATE

TITLE

Zachary Glassburn Administrator 03/17/2025

Any defiency statement 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.

FORM CMS-2567(02-99) Previous Versions Obsolete Event ID: 633F21 Facility ID: 000366 If continuation sheet Page 1 of 18

PRINTED: 03/25/2025 FORM APPROVED OMB NO. 0938-039

AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155469			A. BUILDING B. WING		COMPLETED 03/03/2025		
NAME OF P	ROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD 4410 W 49TH AVE				
CASA OF	HOBART		HOBAF	RT, IN 46342			
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE 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		
	review, the Mainten other documentation update was available Administrator at the became administrate and had not reviewed This finding was rev	ed on interview during record ance Director stated that no in of a more recent review or e. Based on interview with the time of exit, he stated he or of the facility six weeks ago in the EPP since starting.		deficient practice could affect a residents, staff, and visitors in facility. What measures will the facilitate 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 beginning of each year. How will the corrective action be monitored to ensure the practice, i.e., what quality assurance program will be printo place? Emergency Preparedness plan will be reviewed and updated as need in the first quarter Safety Committee meeting annually, deficient practice will be correct upon occurrence.	the ty e d ire the		
E 0013 SS=F Bldg	Development of E	4(b), 418.113(b), 441.1 P Policies and Procedures					
	failed to review and Preparedness Plan (at least annually in a 483.73(b). The LTC implement emergen procedures, based o forth in paragraph (a assessment at paragraph the communication section. The policies reviewed and update	iew and interview, the facility update the Emergency EPP) Policies and Procedures accordance with 42 CFR If facility must develop and cy preparedness policies and in the emergency plan set a) of this section, risk raph (a)(1) of this section, and plan at paragraph (c) of this is and procedures must be end at least annually. This huld affect all residents, staff	E 0013	What corrective action will be accomplished for those residents found to have been affected by the deficient practice? The annual review 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 a	of n		

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

Event ID:

633F21

Facility ID: 000366

If continuation sheet

Page 2 of 18

DEPARTMENT OF HEALTH AND HUMAN SERVICES								
CENTERS FOR MEDICARE & MEDICAID SERVICES								
STATEMENT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION						

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (IDENTIFICATION NUMBER) 155469		(X2) MULT A. BUILD B. WING		(X3) DATE SURVEY COMPLETED 03/03/2025	
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD 4410 W 49TH AVE HOBART, IN 46342		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	PRE	D PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	(X5) COMPLETION DATE
	Maintenance Direct on 03/03/25, docum EPP Policies and Pr 01/03/2024, and not on interview during Maintenance Direct documentation of a was available. Base Administrator at the became administrate and had not reviewed.			residents, staff, and visitors in facility. What measures will the facility alter to ensure that the problem will be corrected a will not recur? Maintenance Director was educated to ensure the deginning of each year. How will the corrective active be monitored to ensure the practice, i.e., what quality assurance program will be into place? Emergency Preparedness Plan Policies and Procedures will be reviewed updated as needed in the first quarter Safety Committee meannually. Any deficient practivill be corrected upon occurring the site of the same annually. Any deficient practivill be corrected upon occurring the safety will be	lity ne he he nd e sure at the put and and et eeting ice
E 0029 SS=F Bldg	Development of C Based on record rev failed to review and Preparedness Comm annually in accordar facility must develo preparedness comm with Federal, State a reviewed and update facilities. This defic residents, staff and v Findings include: Based on record rev	iew and interview, the facility update the Emergency nunication Plan at least nee with 42 CFR 483.73(c). The p and maintain an emergency unication plan that complies and local laws and must be ed at least annually for LTC ient practice could affect all visitors.	E 0029	What corrective action will accomplished for those residents found to have bee 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? The deficient practice could affect residents, staff, and visitors in facility. What measures will the facility	en on ted. he his t all n the

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

Event ID:

633F21

Facility ID: 000366

If continuation sheet

Page 3 of 18

PRINTED: 03/25/2025 FORM APPROVED

ENTERS FOR	R MEDICARE & MEDIC	CAID SERVICES				OM	IB NO. 0938-039	
STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE	SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	A. BUILDING		COMPLETED		
		155469	B. W	ING		03/03/2025		
NAME OF PROVIDER OR SUPPLIER CASA OF HOBART (X4) ID SUMMARY STATEMENT OF DEFICIENCIE			4410 W	ADDRESS, CITY, STATE, ZIP COD V 49TH AVE RT, IN 46342		(X5)		
PREFIX		NCY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		COMPLETION	
TAG		R LSC IDENTIFYING INFORMATION		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	DATE	
E 0036	on 03/03/25, docum EPP Communicati 01/03/2024, and no on interview during Maintenance Direct documentation of a was available. Bass Administrator at the became administral and had not review This finding was re- and Maintenance I	mentation provided showed the on Plan was reviewed on ot in the last 12 months. Based g record review, the		TAG	take or what systems will the facility alter to ensure that the problem will be corrected an will not recur? Maintenance Director was educated to ensure annual review is completed at beginning of each year. How will the corrective action be monitored to ensure the practice, i.e., what quality assurance program will be printo place? Emergency Preparedness Communication Plan will be reviewed and upon as needed in the first quarter Safety Committee meeting annually. Any deficient practice will be corrected upon occurred.	ne d ure the n ut ated	DATE	
SS=F Bldg	Based on record re failed to review an Preparedness Trair least annually in ac 483.73(d). The LT maintain an emerg testing program the plan set forth in pa assessment at parapolicies and proceduces and the co (c) of this section.	resting eview and interview, the facility d update the Emergency ning and Testing Program at ecordance with 42 CFR C facility must develop and ency preparedness training and at is based on the emergency ragraph (a) of this section, risk graph (a)(1) of this section, dures at paragraph (b) of this mmunication plan at paragraph The training and testing eviewed and updated at least icient practice could affect all	E 00	036	What corrective action will be accomplished for those residents found to have been affected by the deficient practice? The annual review Emergency Preparedness Platesting and Training Program 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? The deficient practice could affect residents, staff, and visitors in facility.	of on was e	04/01/2025	

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

Event ID:

633F21

Facility ID: 000366

If continuation sheet

take or what systems will the

Page 4 of 18

	T OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155469	(X2) MULTIPLE (A. BUILDING B. WING	CONSTRUCTION	(X3) DATE SURVEY COMPLETED 03/03/2025
	ROVIDER OR SUPPLIER HOBART		STREET ADDRESS, CITY, STATE, ZIP COD 4410 W 49TH AVE HOBART, IN 46342		
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR	STATEMENT OF DEFICIENCIE 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 APPROPRI DEFICIENCY)	Bitte
E 0039 SS=F Bldg	Maintenance Direct on 03/03/25, docum EPP Testing and Tr on 01/03/2024, and Based on interview Maintenance Direct documentation of a was available. Base Administrator at the became administrate and had not reviewed. This finding was reand Maintenance Direct and Maintenance D	more recent review or update d on interview with the e time of exit, he stated he or of the facility six weeks ago ed the EPP since starting. viewed with the Administrator irector at the exit conference. 5.54(d)(2), 418.113(d)(rements riew and interview, the facility ercises to test the emergency er year, including drills using the emergency C facility must do the ipate in an annual full-scale munity-based; or ity-based exercise is not an annual individual, itonal exercise. y experiences an actual natural gency that requires activation an, the LTC facility is exempt ext required full-scale in a rindividual, facility-based exercise for 1 year following	E 0039	facility alter to ensure that the problem will be corrected at will not recur? Maintenance Director was educated to ensure the sannual review is completed a beginning of each year. How will the corrective action be monitored to ensure the practice, i.e., what quality assurance program will be printo place? Emergency Preparedness Plan Testing a Training Program will be revie and updated as needed in the quarter Safety Committee meannually. Any deficient practice will be corrected upon occurred. 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? The deficient practice could affect residents, staff, and visitors in facility. What measures will the facility alter to ensure that the problem will be corrected and and the corrected and the correct	and sture to the son on out out on out out on out out on out on out on out out out out on out

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

Event ID:

633F21

Facility ID: 000366

If continuation sheet

Page 5 of 18

PRINTED: 03/25/2025 FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155469		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 03/03/2025	
	PROVIDER OR SUPPLIE F HOBART	R	4410 W	ADDRESS, CITY, STATE, ZIP COD V 49TH AVE RT, IN 46342	
(X4) ID PREFIX TAG	a. A second full-secommunity-based functional exercise b. A mock disaster c. A tabletop exercise facilitator that including and a set of proble messages, or preparchallenge an emergence of the second control of the secon	r drill; or vise or workshop that is led by a udes a group discussion, using ly-relevant emergency scenario, m statements, directed ared questions designed to gency plan.	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY) will not recur? Maintenance Director was educated to ensu exercises are completed each year. Administrator and/or designee will audit quarterly to ensure emergency preparedn exercises are completed. How will the corrective actio be monitored to ensure the practice, i.e., what quality	DATE Ure 2 Description of the control of the cont
	maintain documen exercises, and eme LTC facility's eme accordance with 42	TC facility's response to and tation of all drills, tabletop organized events, and revise the regency plan, as needed in 2 CFR 483.73(d)(2). tice could affect all residents,		assurance program will be p into place? Emergency Preparedness Exercises will be reviewed in the quarterly Safe Committee meetings. Any deficient practice will be corre upon occurrence.	pe pe ty
	Maintenance Direct on 03/03/25, the far of a functional fact the facility was un of a second exercismonth period. At Maintenance Direct were conducted.	eview and interview with the etor from 8:35 a.m. to 11:30 a.m. incility provided documentation elity-based exercise, however, able to provide documentation se conducted during the past 12 time of record review the etor stated no other exercises			
K 0000	und Wamtenance I	shoots at the exit conference.			
Bldg. 01	Licensure Survey	e Recertification and State was conducted by the Indiana alth in accordance with 42 CFR	K 0000		

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

Event ID:

633F21

Facility ID: 000366

If continuation sheet

Page 6 of 18

	NT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155469	l í	UILDING	nstruction 01	(X3) DATE COMPL 03/03/	ETED
	PROVIDER OR SUPPLIEF F HOBART	3	STREET ADDRESS, CITY, STATE, ZIP COD 4410 W 49TH AVE HOBART, IN 46342				
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE	(X5) COMPLETION DATE
	Survey Date: 03/03	/2025					
	Facility Number: 00 Provider Number: 10 AIM Number: 1002 At this Life Safety was found not in cofor Participation in Subpart 483.90(a), 2012 edition of the Association (NFPA Chapter 19, Existin 410 IAC 16.2. This facility was subuildings due to the sections of the build built in 1951 as a heconstruction and is 0202 renovated in 10 to be of Type II (11 sprinklered; and Budetermined to be of fully sprinklered, esoutheast sections cone fire alarm syste corridors and space facility has hard-wiresident sleeping rocapacity of 138 and this survey. All areas where reswere sprinklered.	Code survey, Casa of Hobart ompliance with Requirements Medicare/Medicaid, 42 CFR Life Safety from Fire, and the National Fire Protection (1) 101, Life Safety Code (LSC), go Health Care Occupancies and rveyed as three separate econstruction types of three ding: Building 0102 originally buse is of Type V (000) fully sprinklered; Building 1000 (1) construction and is now foliding 0302 built in 1999 was compasses the north and for the facility. The facility has a more with the sopen to the corridors. The red smoke detection in the sopen to the corridors. The red smoke detectors in all the some more didentification of the facility has a consus of 91 at the time of the didents have customary access all areas providing facility					
	Services were spring	npleted on 03/05/25					

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

Event ID:

633F21

Facility ID: 000366

If continuation sheet

Page 7 of 18

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING COMPLETED 01 B. WING 03/03/2025 155469 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 4410 W 49TH AVE CASA OF HOBART **HOBART, IN 46342** (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX PREFIX COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE K 0271 **NFPA 101** SS=E Discharge from Exits Bldg. 01 Based on observation and interview, the facility K 0271 04/01/2025 What corrective action will be failed to ensure exits in 1 of 5 smoke accomplished for those compartments were marked with directional residents found to have been signage. LSC 7.7.3.2 states the exit discharge shall affected by the deficient be arranged and marked to make clear the **practice?** Maintenance Director direction of egress travel from the exit discharge removed sticker signage from the to a public way. This deficient practice could exit door and installed an exit sign affect residents, staff and visitors in 1 of 5 smoke above the door on 3/13/2025. compartments. How will the facility identify other residents having the Findings include: potential to be affected by the same deficient practice? The Based on observation and interview with the deficient practice has the potential Administrator and Maintenance Director from 8:35 to affect all staff, residents and a.m. to 11:30 a.m. on 03/03/25, no directional visitors requiring an exit from this signage was provided in the dining room located dining room area. outside of the memory care unit in an unoccupied What measures will the facility wing of the facility. Two doors in the dining room take or what systems will the were marked as not an exit; however, no signage facility alter to ensure that the was located in the dining room that led to the problem will be corrected and corridor that led to the exit of the building. Based will not recur? Permanent exit on interview at the time of the observation, the sign was installed on 3/13/2025 Maintenance Director acknowledged the dining and will be checked monthly by maintenance director or designee room did not have directional signage and stated he would remove the signs indicating the doors in to ensure compliance. the dining room were not exits. When asked how How will the corrective action someone would know where to exit the dining be monitored to ensure the room, he acknowledged a directional exit sign practice, i.e., what quality would need to be installed in the dining room. assurance program will be put into place? Exit Sign audit This finding was reviewed with the Administrator documentation will be reviewed in and Maintenance Director during the exit the quarterly Safety Committee conference. meeting. Any deficient practice will be corrected upon occurrence. 3.1-19(b)

FORM CMS-2567(02-99) Previous Versions Obsolete Event ID: 633F21 Facility ID: 000366 If continuation sheet Page 8 of 18

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER		· ′	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01		(X3) DATE SURVEY COMPLETED		
		155469	B. WI	NG		03/03/2	2025
	PROVIDER OR SUPPLIER F HOBART		STREET ADDRESS, CITY, STATE, ZIP COD 4410 W 49TH AVE HOBART, IN 46342				
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ATE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
K 0324 SS=E Bldg. 01	facility failed to pro of 1 kitchen exhaus NFPA 96, 2011 Edi Control and Fire Pro	review and interview, the vide documentation to show 1 t systems was inspected. tion, Standard for Ventilation of Commercial	K 0:	324	What corrective action will be accomplished for those residents found to have bee affected by the deficient practice? Kitchen Exhaust	n	04/01/2025
	exhaust system shal buildup by a proper certified person(s) a having jurisdiction at 11.4. Table 11.4, S Grease Buildup, required moderate volume conspected semiannu upon inspection, if the contaminated with vapors, the contaminated system shall be cleated qualified, and certified property of the contaminated with the contaminat	s, Section 11.4 states the entire I be inspected for grease ly trained, qualified, and acceptable to the authority and in accordance with Table chedule for Inspection for quires systems serving boking operations shall be ally. NFPA 96, 11.6.1 states, the exhaust system is found to th deposits from grease laden mated portions of the exhaust med by a properly trained, fied person(s) acceptable to the risdiction. Hoods, grease			System cleaning was completed in July 2024 and documentation was obtained from service provider. Maintenance Direct placed markings on floor in the kitchen to ensure appliances in approved design location upthe 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 the staff, residents and visitors in the event a fire eve	on or ee are nder ne ee eential	
	removal devices, far appurtenances shall combustible contambecoming heavily coily sludge. After tit shall not be coater substance. When an used, a certificate sleservicing company, performing the work cleaning shall be mathematically the shall be mathematically findings include: Based on record rev	_			occurs. What measures will the facil 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 staffire suppression system, propoplacement of equipment and include dietary staff on month fire drills. Maintenance Directors markings are on the fithe kitchen and equipment in approved design location und kitchen hood system. Maintenance Director will aud equipment placement weekly	ity e he aff on her will lly tor to oor in ler the	

PRINTED: 03/25/2025 FORM APPROVED OMB NO. 0938-039

	NT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155469	r í	UILDING	onstruction 01	(X3) DATE COMPL 03/03/	ETED
	PROVIDER OR SUPPLIEI F HOBART	2	STREET ADDRESS, CITY, STATE, ZIP COD 4410 W 49TH AVE HOBART, IN 46342				
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE	(X5) COMPLETION DATE
TAG	on 03/03/25, the fact documentation of a exhaust system inspiriterview at the time Maintenance Direct exhaust cleaning or the exit conference stated he had the doctor locate it in his bid Director contacted if she had the document able to provide kitchen exhaust how been completed. 2.) Based on observing facility failed to provide the completed. 2.) Based on observing facility failed to provide the kitchen have designed and in extinguishing system Ventilation Control Commercial Cooking Edition Section 12. requiring protection or rearranged with fire-extinguishing so or servicing agent, the design of the fire section 12.1.2.3 The shall not require recappliances are moved maintenance and clappliances are return location prior to condition disconnected fire-eattached to the appliance accordance with the manual. Section 12.	cility failed to provide in annual or semiannual kitchen bection or cleaning. Based on e of record review, the for was not aware of a kitchen inspection; however, during the Maintenance Director becumentation but was not able inder. The Maintenance the dietary manager and asked mentation; however, she was any documentation to show a od cleaning or inspection had ration and interview, the ovide an approved method for appliances to where they were bod extinguishing equipment installed for 1 of 1 kitchen hood ms. NFPA 96 Standard for and Fire Protection of ing Operations Section 2011 11.2.2*Cooking appliances in shall not be moved, modified, but prior re-evaluation of the system by the system installer funless otherwise allowed by the extinguishing system the system in the cooking the fire-extinguishing system the system of the purposes of the purposes of the purposes of the purposes of the purpose of the purpose of the med to approved design to obtain the purpose of the med to approved design to obtain the system nozzles the system operations, and any the system operations, and any the system operations are reconnected in the manufacturer's listed design the system operations are reconnected in the manufacturer's listed design the system operations are reconnected in the manufacturer's listed design the system operations are reconnected in the manufacturer's listed design the system operations are reconnected in the manufacturer's listed design the system operations are reconnected in the manufacturer's listed design the system operations are reconnected in the manufacturer's listed design the system operations are reconnected in the manufacturer that the		TAG	How will the corrective action be monitored to ensure the practice, i.e., what quality assurance program will be printo place? Kitchen Exhaust System documentation will be reviewed in the quarterly Safe Committee meeting. Fire Drill documentation will be reviewed the monthly QAPI meeting. A deficient practice will be correctly upon occurrence.	out esty I ed in	DATE

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

Event ID:

633F21

Facility ID: 000366

If continuation sheet Page 10 of 18

PRINTED: 03/25/2025 FORM APPROVED OMB NO. 0938-039

	T OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155469	 JILDING	nstruction 01	(X3) DATE COMPL 03/03/	ETED
	ROVIDER OR SUPPLIER		4410 W	DDRESS, CITY, STATE, ZIP COD 49TH AVE T, IN 46342		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R 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
	* *	d to an approved design ient practice could affect				
	Findings include:					
	Maintenance Direct on 03/03/25, cookin 6-burner stove and located under the he provided with an agensure that the appl approved design loc moved for maintenainterview with the not aware of an app cooking appliances kitchen hood exting designed and install 3.) Based on observed facility failed to ensure of the UL 300 h 1 of 1 kitchen. NFP Control and Fire Procoking Operations instruction shall be regarding the prope extinguishers and the fire-extinguishing einstructions for man extinguishing system conspicuously in the reviewed with employed.	vation and interview, the sure staff were instructed in the mood fire suppression system in vA 96, Standard for Ventilation otection of Commercial s, Section 10.5.7 states provided to employees or use of portable fire the manual activation of equipment. Section 11.1.4 states multiply operating the fire				
	_	4				
	Based on observation	on and interview with the				

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

Event ID:

633F21

Facility ID: 000366

If continuation sheet Page 11 of 18

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155469		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 03/03/2025	
	ROVIDER OR SUPPLIER HOBART		STREET ADDRESS, CITY, STATE, ZIP COD 4410 W 49TH AVE HOBART, IN 46342		
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR	STATEMENT OF DEFICIENCIE 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 0353 SS=F Bldg. 01	on 03/03/25, the kite 300 hood fire supprinterview during too the dietary manager do if there was a great They failed to ment suppression system extinguisher and stattraining. Based on in Director at the time he had never conduction to the conduction of the staff. These findings were Administrator and Mexit conference. 3.1-19(b) NFPA 101 Sprinkler System - 1.) Based on record facility failed to proother evidence the shad been inspected and been inspected and been inspected and been inspected for maintained in according the system required for maintained in according the system of the Inspection, The system of the Inspection, The system of the Inspection, The system of the Inspections, tests, and components and sha authority having juring the system of the Inspection, The system of the Inspections, tests, and components and sha authority having juring the system of th	chen was provided with a UL ession system. Based on ar of the kitchen, a cook and was asked what they would ease fire underneath the hood. ion activating the fire or using the K-Class fire ated they had not received interview with the Maintenance of the kitchen tour, he stated cted any training with the ver conducted a fire drill with - Maintenance Director at the - Maintenance Director at the - Maintenance with the Maintenance or prinkler system components and tested for 3 of 4 quarters. The sany device, equipment or compliance with this Code be dance with applicable NFPA ankler systems shall be properly dance with NFPA 25, Standard Testing, and Maintenance of rotection Systems. NFPA 25, des shall be made for all and maintenance of the system all be made available to the isdiction upon request. 4.3.2 as shall indicate the procedure	K 0353	What corrective action will be accomplished for those residents found to have bee affected by the deficient practice? The annual back fit test was completed on 3/12/2 and the quarterly sprinkler test was completed on 3/12/2025 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 staff, residents an	n ow 025 st and ne e ential
	4.3.1 requires record inspections, tests, at components and sha authority having jur	ds shall be made for all and maintenance of the system all be made available to the disdiction upon request. 4.3.2		other residents having the potential to be affected by the same deficient practice? The	ential

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

Event ID:

633F21

Facility ID: 000366

If continuation sheet

Page 12 of 18

PRINTED: 03/25/2025 FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155469		î ´	JILDING	nstruction 01	COMP	E SURVEY LETED 3/2025		
NAME OF PROVIDER OR SUPPLIER CASA OF HOBART				STREET ADDRESS, CITY, STATE, ZIP COD 4410 W 49TH AVE HOBART, IN 46342				
CASA O (X4) ID PREFIX TAG	summary (EACH DEFICIEN REGULATORY OF performed (e.g., ins the organization that results, and the date waterflow alarm de quarterly to verify t damage. NFPA 25, waterflow alarm de to, water motor gon 5.3.3.2 requires van switch-type waterfl tested semiannually affect all residents, Findings include: Based on record rev Maintenance Direct on 03/03/25, there was system inspection r quarter of 2024 or 2 quarters of 2024. E record review, the M acknowledged there available to show in since an annual insp 04/04/2024. During Director and the Ac contact a corporate believed had receiv attempted to contact performed to inspect Director and Admin had been completed to provide any docu inspections had bees interview at the tim Maintenance Director	view and interview with the sor from 8:35 a.m. to 11:30 a.m. was no quarterly sprinkler eports available for the first 2025, or the third or fourth based on interview at the time of Maintenance Director e was no documentation aspections had been completed pection conducted on the survey, the Maintenance liministrator attempted to representative that they ed the reports, they also				fire event the facility s will the te that the tected and Maintenance ated on rinkler tests flow test is manner. tecompleted tesignee to ve action ure the tality will be put Inspection tentation will arterly Safety Any deficient	(XS) COMPLETION DATE	

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

Event ID:

633F21

Facility ID: 000366

If continuation sheet

Page 13 of 18

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155469		A. BUILDING 01 B. WING		CON	(X3) DATE SURVEY COMPLETED 03/03/2025			
NAME OF PROVIDER OR SUPPLIER CASA OF HOBART			4410 W	STREET ADDRESS, CITY, STATE, ZIP COD 4410 W 49TH AVE HOBART, IN 46342				
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO T DEFICIENCY	ON SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE		
	interview, the facili prevention device in was tested annually NFPA 25, Standard and Maintenance of Systems, 2011 Edit backflow preventer system piping shall conducting a forwar the designed flow redemand, where hydrogen are located downstr. This deficient pract staff and visitors. Findings include: Based on record revent Maintenance Direct on 03/03/25, there we backflow preventer past year on the backgrinkler system was observation with the 11:33 a.m. to 2:32 preventer was observation with the Administrator as corporate representation received the reports contact the contract inspections. The Madministrator state completed; however provide any documinspections had been interview at the tim Maintenance Direct	review, observation and try failed ensure 1 of 1 backflow in the sprinkler system piping in accordance with NFPA 25. for the Inspection, Testing, Water-Based Fire Protection ion, Section 13.6.2.1 states all is installed in fire protection be tested annually by red flow test of the system at ate, including hose stream rants or inside hose stations eam of the backflow preventer. ice could affect all residents, itee could affect all residents, was no record of an annual available for review over the elekflow preventer device for the ater supply. Based on the Maintenance Director from 5.m. on 03/03/25, a backflow reved on the sprinkler system. The Maintenance Director and attempted to contact a strive that they believed had, they also attempted to or that performed to anintenance Director and do the inspections had been referred to sent at the contact and the inspections had been referred. Based on the of record review, both the contact the Administrator and						

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

Event ID:

633F21

Facility ID: 000366

If continuation sheet

Page 14 of 18

		X1) PROVIDER/SUPPLIER/CLIA			(X3) DATE	ATE SURVEY	
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER	A. BUILDING <u>01</u>		COMPL	COMPLETED	
155469		155469	B. WING			03/03/2025	
<u>l</u>				CTREET	ADDRESS, CITY, STATE, ZIP COD		
NAME OF PROVIDER OR SUPPLIER					49TH AVE		
CASA OF HOBART				_			
CASA OF	HUDAKI			HOBAN	RT, IN 46342		
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE		COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	contractors.						
	These findings were	e reviewed with the					
	Administrator and M	Maintenance Director at the					
	exit conference.						
	3.1-19(b)						
K 0511	NFPA 101					ļ	
SS=E	Utilities - Gas and	Electric					
Bldg. 01							
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)		K 0	511	What corrective action will be accomplished for those		04/01/2025	
			residents found to have been		1		
				affected by the deficient			
	protection against electric shock. LSC 19.5.1.1				practice? The GFCI outlet was		
	-	nply with Section 9.1. LSC			replaced by the Maintenance		
	-	ical wiring and equipment to			Director.		
		70, National Electrical Code.			How will the facility identify		
		1 Edition at 210.8 Ground-Fault			other residents having the		
	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,				potential to be affected by th	е	
					same deficient practice? The	9	
					deficient practice has the pote	ntial	
					to affect all staff, residents and	1	
					visitors.		
					What measures will the facili	ty	
					take or what systems will the		
		d 20-ampere receptacles			facility alter to ensure that th	е	
		tions specified in 210.8(B)(1)			problem will be corrected an	d	
	through (8) shall ha	_			will not recur? GFCI outlets v	will	
	circuit-interrupter p	rotection for personnel.			be tested monthly by the		
	(1) Bathrooms				Maintenance Director to ensur	e	
	(2) Kitchens				proper functioning. A monthly		
	(3) Rooftops				audit of GFCI outlet testing log	js	
	(4) Outdoors				will be conducted by the	ļ	
	-	(3) and (4): Receptacles that are			administrator or designee to	ļ	
		le and are supplied by a			ensure compliance.	ļ	
		ated to electric snow-melting,			How will the corrective action	n	
		and vessel heating equipment			be monitored to ensure the	ļ	
shall be permitted to be installed in accordance		be installed in accordance			practice, i.e., what quality		

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

Event ID:

633F21

Facility ID: 000366 If continuation sheet Page 15 of 18

NAME OF PROVIDER OR SUPPLIER CASA OF HOBART (X4) ID SUMMARY STATEMENT OF DEFICIENCIE PREFIX TAG SUMMARY STATEMENT OF DEFICIENCIE REGULATORY OR LSC IDENTIFYING INFORMATION TAG 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	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155469		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 03/03/2025	
PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION 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. 2 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			4410 W	49TH AVE		
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	PREFIX	(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	COMPLETION	
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.	1AG	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	TAG	assurance program will be p into place? GFCI outlet testir documentation will be reviewe the quarterly Safety Committe meeting. Any deficient practic	ut ng d in e e	

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

Event ID:

633F21

Facility ID: 000366

If continuation sheet Page 16 of 18

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155469		(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 01	(X3) DATE SURVEY COMPLETED 03/03/2025	
	ROVIDER OR SUPPLIER		4410 W	ADDRESS, CITY, STATE, ZIP COD V 49TH AVE RT, 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 APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
K 0712 SS=F Bldg. 01	Maintenance Direct on 03/03/25, there winches from the sink care unit. The elect fault circuit interrupt interrupt electrical patester. This was conditioned by Director at the time. This finding was reat the exit conference of t	viewed with the Administrator ce. View and interview, the facility of 12 fire drills in 4 of 4 most recent twelve month time 6 requires drills to be on each shift under varied ficient practice affects all staff View and interview with the for from 8:35 a.m. to 11:30 a.m. cility was unable to provide re drills for: the first quarter of 2024 or 2025, second quarter of 2024,	K 0712	What corrective action will be accomplished for those residents found to have been affected by the deficient practice? A second shift fire was conducted on 3/13/2025 frompliance in the first quarter 2025. Fire drills to be conduct monthly and across all three seach 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 ever occurs. What measures will the facility take or what systems will the	drill for of ded hifts e e ntial d ht

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

Event ID:

633F21

Facility ID: 000366

If continuation sheet

Page 17 of 18

PRINTED: 03/25/2025 FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155469	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 03/03/2025	
NAME OF PROVIDER OR SUPPLIER CASA OF HOBART			4410 W	ADDRESS, CITY, STATE, ZIP COD / 49TH AVE RT, IN 46342		
(X4) ID PREFIX TAG	(EACH DEFICIE)	STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R 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
	with the requireme	t fire drills but was not familiar ents. eviewed with the Administrator Director at the exit conference.		facility alter to ensure that the problem will be corrected and will not recur? The Maintenan Director was re-educated on the requirements to conduct fire done very shift, every quarter. In monthly audit of fire drill logs who be conducted by the administry or designee to ensure compliant How will the corrective action be monitored to ensure the practice, i.e., what quality assurance program will be printo place? Fire Drill documentation will be reviewed the monthly QAPI meeting. And deficient practice will be correct upon occurrence.	d ince he rills A will rator ance. n	

FORM CMS-2567(02-99) Previous Versions Obsolete Event ID: 633F21 Facility ID: 000366 If continuation sheet Page 18 of 18