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	07/14/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF 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: 07/14/21 Facility Number: 000366 Provider Number: 155469 AIM Number: 100288900 At this Emergency Preparedness survey, Casa of Hobart was found in compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 483.73 The facility has 138 certified beds. At the time of the survey, the census was 84. Quality Review completed on 07/28/21	E 0000		
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). Survey Date: 07/14/21 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	K 0000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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	07/14/2021

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	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 wired smoke detectors in all resident sleeping rooms. The facility has a capacity of 138 and a census of 84 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 07/28/21			
K 0222 SS=E Bldg. 01	NFPA 101 Egress Doors Egress Doors Doors in a required means of egress shall not be equipped with a latch or a lock that requires the use of a tool or key from the egress side unless using one of the following special locking arrangements: CLINICAL NEEDS OR SECURITY THREAT			

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	LOCKING Where special locking arrangements for the clinical security needs of the patient are used, only one locking device shall be permitted on each door and provisions shall be made for the rapid removal of occupants by: remote control of locks; keying of all locks or keys carried by staff at all times; or other such reliable means available to the staff at all times. 18.2.2.2.5.1, 18.2.2.2.6, 19.2.2.2.5.1, 19.2.2.2.6 SPECIAL NEEDS LOCKING ARRANGEMENTS Where special locking arrangements for the safety needs of the patient are used, all of the Clinical or Security Locking requirements are being met. In addition, the locks must be electrical locks that fail safely so as to release upon loss of power to the device; the building is protected by a supervised automatic sprinkler system and the locked space is protected by a complete smoke detection system (or is constantly monitored at an attended location within the locked space); and both the sprinkler and detection systems are arranged to unlock the doors upon activation. 18.2.2.2.5.2, 19.2.2.2.5.2, TIA 12-4 DELAYED-EGRESS LOCKING ARRANGEMENTS Approved, listed delayed-egress locking systems installed in accordance with 7.2.1.6.1 shall be permitted on door assemblies serving low and ordinary hazard contents in buildings protected throughout by an approved, supervised automatic fire detection system or an approved, supervised automatic sprinkler system. 18.2.2.2.4, 19.2.2.2.4			

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	ACCESS-CONTROLLED EGRESS LOCKING ARRANGEMENTS Access-Controlled Egress Door assemblies installed in accordance with 7.2.1.6.2 shall be permitted. 18.2.2.2.4, 19.2.2.2.4 ELEVATOR LOBBY EXIT ACCESS LOCKING ARRANGEMENTS Elevator lobby exit access door locking in accordance with 7.2.1.6.3 shall be permitted on door assemblies in buildings protected throughout by an approved, supervised automatic fire detection system and an approved, supervised automatic sprinkler system. 18.2.2.2.4, 19.2.2.2.4 Based on observation and interview, the facility failed to ensure the delayed egress locking arrangements were installed in accordance with LSC Section 19.2.2.2.4 in 1 of 7 exits. Section 19.2.2.2.4 states that doors within a required means of egress shall not be equipped with a latch or lock that requires the use of a tool or key from the egress side, unless otherwise permitted. Section 19.2.2.2.4 (2) states that delayed-egress locks complying with 7.2.1.6.1 shall be permitted. LSC 7.2.1.6.1(3) states an irreversible process shall release the lock in the direction of egress within 15 seconds, or 30 seconds where approved by the authority having jurisdiction, upon application of a force to the release device required in 7.2.1.5.10 under all of the following conditions: (a) The force shall not be required to exceed 15 lbf (67 N). (b) The force shall not be required to be continuously applied for more than 3 seconds. (c) The initiation of the release process shall activate an audible signal in the vicinity of the door opening.	K 0222	**K222 NFPA 101 EGRESS DOOR** **The facility requests paper compliance for this citation.** *This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.* **1) Immediate actions taken for those residents identified:**	08/06/2021

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	(d) Once the lock has been released by the application of force to the releasing device, relocking shall be by manual means only. This deficient practice could affect all staff within the service hall of the facility. Findings include: During a tour of the facility with the Administrator, Assistant Administrator and Maintenance Director on 07/14/21 at 1:19 p.m., when the 15 second delayed egress door was pushed in the employee entrance, the irreversible process to release the lock was not initiated, and there was no audible signal. The door had an sign stating to push until alarm sounds. Door can be opened in 15 seconds. The door would not release after 15 seconds after multiple attempts. A door code was posted at the door, and the egress door opened after the code was entered. Based on interview at the time of observation, the Administrator and Maintenance Director agreed the door lock did not release with the 15 second delay egress. This finding was reviewed with the Administrator, Assistant Administrator and Maintenance Director at the time of exit. 3.1-19(b)		· Employee entrance door signage stating that door will open after 15 seconds was removed. Access to egress will be by use of code posted by keypad. There were no residents cited in regard to this regulation. **2) How the facility identified other residents:** · Staff employed at the community have the potential to be affected by the alleged deficient practice. **3) Measures put into place/ System changes:** · The Maintenance Department will inspect exit doors weekly to ensure proper functioning and will document on the Preventative Maintenance Worksheet. The Maintenance Director will be re-educated on the Preventative Maintenance Program by the Executive Director/designee by 8/6/21. · The Maintenance Director is responsible for compliance. **4) How the corrective actions will be monitored:** · An Environmental QAPI tool will be utilized weekly x 4 and monthly thereafter, to monitor	

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			compliance. · · The results of these audits will be reviewed in Quality Assurance Meeting monthly for 6 months or until 100% compliance is achieved. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated. **5) Date of compliance:** 8/6/2021	
K 0353 SS=E Bldg. 01	NFPA 101 Sprinkler System - Maintenance and Testing Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked _____ b) Who provided system test _____ c) Water system supply source _____ Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 Based on observation and interview, the facility failed to maintain the ceiling construction in 1 of 1 Mechanical rooms. NFPA 13, 2010 edition,	K 0353	**K 353 NFPA 101 SPRINKLER SYSTEM – MAINTENANCE AND TESTING**	08/06/2021

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	Section 3.3.5.4 defines a smooth ceiling as a continuous ceiling free from significant irregularities, lumps, or indentations. The ceiling traps hot air and gases around the sprinkler and cause the sprinkler to operate at a specified temperature. Section 8.5.4.1.1 states the distance between the sprinkler deflector and the ceiling above shall be selected based on the type of sprinkler and the type of construction. This deficient practice could affect 18 residents, staff, and visitors in the vicinity of the Mechanical room by Bakersfield Hall. Findings include: Based on observation with the Administrator, Assistant Administrator and Maintenance Director during a tour of the facility from 12:22 p.m. to 1:52 p.m. on 07/14/21, the following was noted in the Mechanical room by resident room 71: a) suspended ceiling tile missing leaving 12 inch X 12 inch opening to the ceiling grid above near the wall opposite the door. b) one inch annular space around a pipe penetrating the suspended ceiling c) onc inch annular space around over 8 cables penetrating the suspended ceiling near the door. The room was equipped with two pendant sprinkler installed on the suspended ceiling. Based on interview at the time of the observations, the Administrator and Maintenance Director acknowledged the missing ceiling tile and unsealed penetrations in the aforementioned room. This finding was reviewed with the Administrator, Assistant Administrator and Maintenance Director at the exit conference.		**The facility requests paper compliance for this citation.** *This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is* **1) Immediate actions taken for those residents identified:** · Ceiling tiles in mechanical room near room 71 were replaced and penetrations were sealed. One-inch annular space around the pipes and annular space around 8 cables penetrating the suspended ceiling were sealed. There were no residents cited in regard to this regulation. **2) How the facility identified other residents:** · Staff, Visitors and Residents have the potential to be affected by the alleged deficient practice.	

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	3.1-19(b)		**3) Measures put into place/ System changes:** · Inspection of suspended ceiling will be completed weekly and documented on the Preventative Maintenance Worksheet Log by the Maintenance Department. · The Maintenance Department will be re-educated on the Preventative Maintenance Program by the Executive Director/designee by 8/6/21. · The Maintenance Director is responsible for compliance. **4. How the corrective actions will be monitored:** · An Environmental QAPI tool will be utilized weekly x 4 and monthly thereafter, to monitor compliance. · The results of these audits will be reviewed in Quality Assurance Meeting monthly for 6 months or until 100% compliance is achieved. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated 5. **Compliance Date:** 8/6/21	

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K 0372 SS=E Bldg. 01	NFPA 101 Subdivision of Building Spaces - Smoke Barrie Subdivision of Building Spaces - Smoke Barrier Construction 2012 EXISTING Smoke barriers shall be constructed to a 1/2-hour fire resistance rating per 8.5. Smoke barriers shall be permitted to terminate at an atrium wall. Smoke dampers are not required in duct penetrations in fully ducted HVAC systems where an approved sprinkler system is installed for smoke compartments adjacent to the smoke barrier. 19.3.7.3, 8.6.7.1(1) Describe any mechanical smoke control system in REMARKS.			
	Based on observation and interview, the facility failed to ensure the penetrations caused by the passage of wire and/or conduit through 4 of 6 smoke barrier walls were protected to maintain the smoke resistance of each smoke barrier. LSC Section 19.3.7.5 requires smoke barriers to be constructed in accordance with LSC Section 8.5 and shall have a minimum ½ hour fire resistive rating. This deficient practice could affect staff and at least 34 residents and staff. Findings include: Based on observations with the Administrator, Assistant Administrator and Maintenance Director on 07/13/21 during a tour of the facility at 1:48 p.m., the following unsealed penetration was discovered: a) a two inch by two inch gap in the smoke barrier above the suspended ceiling by resident room 1. Based on interview at the time of observation, the Administrator and Maintenance Director	K 0372	**K372 NFPA 101 SUBDIVISION OF BUILDING SPACES – SMOKE BARRIER** **The facility requests paper compliance for this citation.** *This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.*	08/06/2021

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	acknowledged the aforementioned condition and provided the measurements. This finding was reviewed with the Administrator, Assistant Administrator and Maintenance Director at the exit conference. 3.1-19(b)		**1) Immediate actions taken for those residents identified:** · There were no residents cited in regard to this regulation. · The penetrations above ceiling tile near resident room 1 has been repaired. **2) How the facility identified other residents:** · Residents, staff and visitors have the potential to be affected by the alleged deficient practice. **3) Measures put into place/ System changes:** · Outside contractors will be educated, prior to completing services on the building, about proper fire wall penetrations. The Maintenance Director/designee will inspect for penetrations prior to job completion. · The Maintenance Director is responsible for compliance. **4) How the corrective actions will be monitored:** · An Environmental QAPI tool will be utilized monthly to monitor compliance with smoke barrier walls. · The results of these audits will be reviewed in Quality Assurance Meeting monthly for 6	

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			months or until 100% compliance is achieved. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated **5) Date of compliance:** · 8/6/21	
K 0918 SS=F Bldg. 01	NFPA 101 Electrical Systems - Essential Electric Syste Electrical Systems - Essential Electric System Maintenance and Testing The generator or other alternate power source and associated equipment is capable of supplying service within 10 seconds. If the 10-second criterion is not met during the monthly test, a process shall be provided to annually confirm this capability for the life safety and critical branches. Maintenance and testing of the generator and transfer switches are performed in accordance with NFPA 110. Generator sets are inspected weekly, exercised under load 30 minutes 12 times a year in 20-40 day intervals, and exercised once every 36 months for 4 continuous hours. Scheduled test under load conditions include a complete simulated cold start and automatic or manual transfer of all EES loads, and are conducted by competent personnel. Maintenance and testing of stored energy power sources (Type 3 EES) are in accordance with NFPA 111. Main and feeder circuit breakers are inspected annually, and a program for periodically exercising the components is established according to manufacturer requirements. Written records			

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	of maintenance and testing are maintained and readily available. EES electrical panels and circuits are marked, readily identifiable, and separate from normal power circuits. Minimizing the possibility of damage of the emergency power source is a design consideration for new installations. 6.4.4, 6.5.4, 6.6.4 (NFPA 99), NFPA 110, NFPA 111, 700.10 (NFPA 70) Based on record review and interview, the facility failed to maintain a complete written record of monthly generator load testing for 8 of the last 12 months and ensured the generator ran for 30 minutes. Chapter 6.4.4.1.1.4(a) of 2012 NFPA 99 requires monthly testing of the generator serving the emergency electrical system to be in accordance with NFPA 110, the Standard for Emergency and Standby Powers Systems, Chapter 8. NFPA 110 8.4.2 requires diesel generator sets in service to be exercised at least once monthly, for a minimum of 30 minutes. Chapter 6.4.4.2 of NFPA 99 requires a written record of inspection, performance, exercising period, and repairs for the generator to be regularly maintained and available for inspection by the authority having jurisdiction. This deficient practice could affect all occupants. Findings include: Based on records review with the Administrator and Maintenance Director on 07/14/21 at 12:00 p.m., no documentation was available for review to show the diesel generator set in service was exercised at least once monthly for the months of November, December of 2020, January, February, March, April, May, June of 2021. Based on an interview at the time of record review, the Administrator acknowledged the	K 0918	**K918 NFPA 101 ELECTRICAL SYSTEM- ESSENTIAL ELECTRIC SYSTEM** **The facility requests paper compliance for this citation.** *This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.* **1) Immediate actions taken for those residents identified:** · The Monthly generator load tested was completed on….. **2) How the facility identified**	08/06/2021

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	monthly generator tests were not conducted during the aforementioned months and there were no further documents to review. The Maintenance Director has only been employed at the facility for two weeks and can not speak to testing before he was hired. This finding was reviewed with the Administrator, Assistant Administrator and Maintenance Director at the exit conference. 3.1-19(b)		**other residents:** · Residents, staff and visitors have the potential to be affected by the alleged deficient practice. **2) Measures put into place/ System changes:** · The Maintenance Department will inspect and completed monthly generator load tested to ensure proper functioning and will document on the Preventative Maintenance Worksheet. The Maintenance Director will be re-educated on the Preventative Maintenance Program by the Executive Director/designee by 8/6/21. · The Maintenance Director is responsible for compliance. **4) How the corrective actions will be monitored:** · An Environmental QAPI tool will be utilized monthly to monitor compliance. · The results of these audits will be reviewed in Quality Assurance Meeting monthly for 6 months or until 100% compliance is achieved. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as	

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			indicated **5) Date of compliance:** 8/6/21	
K 0923 SS=E Bldg. 01	NFPA 101 Gas Equipment - Cylinder and Container Storag Gas Equipment - Cylinder and Container Storage Greater than or equal to 3,000 cubic feet Storage locations are designed, constructed, and ventilated in accordance with 5.1.3.3.2 and 5.1.3.3.3. >300 but <3,000 cubic feet Storage locations are outdoors in an enclosure or within an enclosed interior space of non- or limited- combustible construction, with door (or gates outdoors) that can be secured. Oxidizing gases are not stored with flammables, and are separated from combustibles by 20 feet (5 feet if sprinklered) or enclosed in a cabinet of noncombustible construction having a minimum 1/2 hr. fire protection rating. Less than or equal to 300 cubic feet In a single smoke compartment, individual cylinders available for immediate use in patient care areas with an aggregate volume of less than or equal to 300 cubic feet are not required to be stored in an enclosure. Cylinders must be handled with precautions as specified in 11.6.2. A precautionary sign readable from 5 feet is on each door or gate of a cylinder storage room, where the sign includes the wording as a minimum "CAUTION: OXIDIZING GAS(ES) STORED WITHIN NO SMOKING." Storage is planned so cylinders are used in			

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	155469	A. BUILDING 01 B. WING	07/14/2021

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

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	order of which they are received from the supplier. Empty cylinders are segregated from full cylinders. When facility employs cylinders with integral pressure gauge, a threshold pressure considered empty is established. Empty cylinders are marked to avoid confusion. Cylinders stored in the open are protected from weather. 11.3.1, 11.3.2, 11.3.3, 11.3.4, 11.6.5 (NFPA 99)			
	Based on observation and interview, the facility failed to ensure 1 of 1 cylinders of nonflammable gases such as oxygen were properly secured from falling. NFPA 99, Health Care Facilities Code, 2012 Edition, Section 11.3.2 states storage for nonflammable gases greater than 8.5 cubic meters (300 cubic feet) but less than 85 cubic meters (3000 cubic feet) shall comply with 11.3.2.1 through 11.3.2.3. NFPA 99, Section 11.3.2.6 states cylinder or container restraints shall comply with 11.6.2.3. Section 11.6.2.3(11) states freestanding cylinders shall be properly chained or supported in a proper cylinder stand or cart. This deficient practice could affect 28 residents and staff in the vicinity of the main nurses station. Findings include: Based on observation with the Administrator, Assistant Administrator, and Maintenance Director during a tour of the facility from 12:22 p.m. to 1:52 p.m. on 07/14/21, one 'E' type oxygen cylinders was standing upright on the floor in a corner between two offices in the main nurse's station and was not properly chained or supported in a proper cylinder stand or cart. Based on interview at the time of observation, the Administrator acknowledged the 'E' type oxygen cylinders in the aforementioned location	K 0923	**K923 NFPA GAS EQUIPMENT – CYLINDER AND CONTRAINER STORAGE** **The facility requests paper compliance for this citation.** *This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.* **1) Immediate actions taken for those residents identified:** · Oxygen Cylinder was removed from main nurse's station.	08/06/2021

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	was not properly chained or supported in a proper cylinder stand or cart. This finding was reviewed with the Administrator, Assistant Administrator and Maintenance Director at the exit conference. 3.1-19(b)		**2) How the facility identified other residents:** · Staff have the potential to be affected by the alleged deficient practice. **3) Measures put into place/ System changes:** · Staff will be re-educated on the proper storage of oxygen cylinders by maintenance Director/designee by 8/6/21. · An audit tool will be developed to ensure proper storage of oxygen cylinders. Observation will be completed three times weekly for 4 weeks then 2x weekly for 6 months. Any deficiencies will be corrected immediately. · The Maintenance Director or designee is responsible for compliance. **1) How the corrective actions will be monitored:** · The results of these audits will be reviewed in Quality Assurance Meeting monthly for 6 months or until 100% compliance is achieved. The QA Committee will identify any trends or patterns and make recommendations to	

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			revise the plan of correction as indicated **5) Date of compliance:** · 8/6/21	