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	11/14/2022

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: 11/14/22 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 93. Quality Review completed on 11/16/22	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: 11/14/22 Facility Number: 000366 Provider Number: 155469 AIM Number: 100288900 At this Life Safety Code survey, Casa of Hobart	K 0000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Rosa McGowen	RVP	12/01/2022

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.

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	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 wired smoke detectors in all resident sleeping rooms. The facility has a capacity of 138 and a census of 93 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 11/16/22			
K 0372 SS=B 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			

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	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 1 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 at least 44 residents and staff. Findings include: Based on observations with the Administrator and Maintenance Director on 11/14/22 during a tour of the facility at 1:20 p.m., there was a one inch by one inch opening in the smoke barrier above the suspended ceiling by resident room 17 around a cable running through the wall. The firestop material around the cable had pulled away from the wall. Based on interview at the time of observation, the Maintenance Director confirmed that the unsealed opening in the above mentioned smoke wall. The Maintenance Director sealed the penetration prior to survey exit. This finding was reviewed with the Administrator and Maintenance Director at the exit conference. 3.1-19(b)	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.* **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 17 has been repaired.	11/15/2022

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			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 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:**	

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			· 11/15/22	
K 0521 SS=E Bldg. 01	NFPA 101 HVAC HVAC Heating, ventilation, and air conditioning shall comply with 9.2 and shall be installed in accordance with the manufacturer's specifications. 18.5.2.1, 19.5.2.1, 9.2 Based on record review, observation and interview; the facility failed to ensure fire dampers in the facility were inspected and provided necessary maintenance at least every four years in accordance with NFPA 90A. LSC 9.2.1 requires heating, ventilating and air conditioning (HVAC) ductwork and related equipment shall be in accordance with NFPA 90A, Standard for the Installation of Air-Conditioning and Ventilating Systems. NFPA 90A, 2012 Edition, Section 5.4.8.1 states fire dampers shall be maintained in accordance with NFPA 80, Standard for Fire Doors and Other Opening Protectives. NFPA 80, 2010 Edition, Section 19.4.1 states each damper shall be tested and inspected 1 year after installation. The test and inspection frequency shall be every 4 years. If the damper is equipped with a fusible link, the link shall be removed for testing to ensure full closure and lock-in-place if so equipped. The damper shall not be blocked from closure in any way. All inspections and testing shall be documented, indicating the location of the fire damper, date of inspection, name of inspector and deficiencies discovered. The documentation shall have a space to indicate when and how the deficiencies were corrected. This deficient practice could affect at least 40 residents, staff and visitors. Findings include:	K 0521	**K521 NFPA 101 HVAC** **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:** · Dampers located in the attic were inspected. **2) How the facility identified other residents:**	11/15/2022

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	Based on observation during a tour of the facility on 11/14/22 from 12:15 p.m. to 1:25 p.m. with the Maintenance Director, three fire dampers were observed installed in the attic. The fire dampers were in the wall that included the stairwell door assembly at the top of the stairs. Wrote on the fusible links on the dampers with a black marker was '10/30 and 10/4'. There were no other documentation affixed to the dampers to determine install date or inspection dates. Based on interview at the time of observation, the Maintenance Director confirmed there were fire dampers installed in the facility and was unsure if there was four year inspection documentation. At the time of survey exit, no fire damper inspection documentation was available for review. This finding was reviewed with the Administrator and Maintenance Director at the exit conference. 3.1-19(b)		· Residents, staff and visitors have the potential to be affected by the alleged deficient practice. **3) Measures put into place/ System changes:** · The Maintenance Director will be re-educated on the Preventative Maintenance Program by the Executive Director/designee by 11/15/22. · 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 indicated **5) Date of compliance:** · 11/15/22	
K 0918 SS=F	NFPA 101 Electrical Systems - Essential Electric Syste			

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Bldg. 01	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 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 ensure a written record of weekly inspections for the generator was maintained for 17 of 52 weeks. NFPA 99, 6.4.4.1.3 requires onsite	K 0918	**K918 NFPA ELECTICAL SYSTEM – ESSENTIAL ELECTRIC SYSTEM**	11/15/2022

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	generators shall be maintained in accordance with NFPA 110, Standard for Emergency and Standby Power Systems. NFPA 110, 8.4.1 requires an Emergency Power Supply System (EPSS) including all appurtenant components, shall be inspected weekly and exercised monthly. NFPA 99, 6.4.4.2 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 residents, staff and visitors. Findings include: Based on record review with the Maintenance Director on 11/14/22 from 9:40 a.m. to 12:15 p.m., documentation for weekly generator testing was not available for review from 12/07/2021 to 04/12/2022. Based on an interview at the time of record review, the Maintenance Director stated he became employed at the facility in April 2022 and no other weekly generator testing documentation was available for review at the time of the survey. This finding was reviewed with the Administrator and Maintenance Director at the exit conference. 3.1-19(b)		**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:** · Education provided to Maintenance Director about preventative maintenance. **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:** · Administrator will complete weekly audit for 4 weeks, then	

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			monthly thereafter to ensure Generator weekly testing was completed and recorded. · 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 revise the plan of correction as indicated **5) Date of compliance:** · 11/15/22	