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 _____	R **01/08/2024**

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
{K 000}	INITIAL COMMENTS A Post Survey Revisit (PSR) to the Life Safety Code Recertification and State Licensure Survey conducted on 11/16/23 was conducted by the Indiana Department of Health in accordance 42 CFR Subpart 483.90(a). Survey Date: 01/08/24 Facility Number: 000366 Provider Number: 155469 AIM Number: 100288900 At this Life Safety Code PSR, Casa of Hobart was found 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 85 at the time of	{K 000}		

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 _____	R **01/08/2024**

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{K 000}	Continued From page 1 this survey. All areas where residents have customary access were sprinklered. All areas providing facility services were sprinklered. Quality Review completed on 01/09/24	{K 000}		