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 _____	R-C 01/31/2024

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
{F 000}	INITIAL COMMENTS	{F 000}		

This visit was for a Post Survey Revisit (PSR) to the Investigation of Complaint IN00421764.

This visit was in conjunction with the Investigation of Complaints IN00426522 and IN00426603.

Complaint IN00421764 - Corrected.

Complaint IN00426522 - No deficiencies related to the allegations are cited.

Complaint IN00426603 - No deficiencies related to the allegations are cited.

Survey date: January 31, 2024

Facility number: 000366
Provider number: 155469
AIM number: 100288900

Census Bed Type:
SNF/NF: 92
Total: 92

Census Payor Type:
Medicare: 8
Medicaid: 58
Other: 26
Total: 92

Casa of Hobart was found to be in compliance with 42 CFR Part 483 Subpart B and 410 IAC 16.2-3.1 in regard to the PSR to the Investigation of Complaint IN00421764.

Quality review completed on 2/6/24.

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