STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING B. WING	07/16/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRENTWOOD AT HOBART	1420 ST MARYS CIRCLE, HOBART, , 46342

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES...	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION...	(X5) COMPLETION DATE
R 0000	INITIAL COMMENTS This visit was for the Investigation of Complaints IN00462838, IN00463132, and IN00463417. Complaint IN00462838 - State deficiency related to the allegations are cited at R0349. Complaint IN00463132 - State deficiencies related to the allegations are cited at R0216 and R0275. Complaint IN00463417 - State deficiency related to the allegations are cited at R0305. Survey date: July 16, 2025 Facility number: 002627 Residential Census: 110 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review completed on 7/21/25.	R 0000	The submission of this plan of correction does not indicate an admission by Brentwood at Hobart that the findings and allegations contained herein are an accurate, true representation of the quality of care provided, and living environment provided to the residents of Brentwood at Hobart. The community hereby maintains it is in substantial compliance with the requirements of participation for residential care facilities. Please accept this plan of correction as the credible allegation of compliance with all state and federal requirements governing the management of this facility. Brentwood at Hobart respectfully request from the department a desk review/paper compliance for these tags.	

R 0216	Evaluation - Noncompliance 410 IAC 16.2-5-2(c)(1-4)(d) (c) The scope and content of the evaluation shall be delineated in the facility policy manual, but at a minimum the needs assessment shall include an evaluation of the following: (1) The resident ' s physical, cognitive, and mental status. (2) The resident ' s independence in the activities of daily living. (3) The resident ' s weight taken on admission and semiannually thereafter. (4) If applicable, the resident ' s ability to self-administer medications. (d) The evaluation shall be documented in writing and kept in the facility. Based on record review and interview, the facility failed to ensure a resident's weight was recorded on admission for 1 of 4 residents reviewed for weight loss. (Resident D) Finding includes:	R 0216	It is the policy of this community that resident weights are recorded in their medical record. No adverse effects were noted for any resident involved in this deficient practice. An audit was completed ensuring all residents had admission weights completed. The DON/Designee will complete admission chart audits within 24hrs of admission to ensure weights are completed. This will continue indefinitely. The DON/Designee will review all admissions weekly to ensure all information is documented correctly. All results will be reviewed monthly during QA meetings.	08/08/2025

	The record for Resident D was reviewed on 7/16/25 at 11:30 a.m. There were no diagnoses listed for the resident. The resident was admitted to the facility on 4/18/25. The record lacked documentation of the resident's weight upon admission. On 5/9/25 and 5/14/25 the resident weighed 90 pounds. There were no documented weights for the months of June 2025 and July 2025. A weight was obtained on 7/16/25 and the resident weighed 103 pounds. During an interview on 7/16/25 at 3:15 p.m., the Director of Nursing indicated the resident's admission weight should have been documented, that way they would know if she had lost weight or gained weight. This citation relates to Complaint IN00463132. Based on record review and interview, the facility failed to ensure a resident's weight was recorded on admission for 1 of 4 residents reviewed for weight loss. (Resident D) Finding includes: The record for Resident D was reviewed on 7/16/25 at 11:30 a.m. There were no diagnoses listed for the resident. The			

	resident was admitted to the facility on 4/18/25. The record lacked documentation of the resident's weight upon admission. On 5/9/25 and 5/14/25 the resident weighed 90 pounds. There were no documented weights for the months of June 2025 and July 2025. A weight was obtained on 7/16/25 and the resident weighed 103 pounds. During an interview on 7/16/25 at 3:15 p.m., the Director of Nursing indicated the resident's admission weight should have been documented, that way they would know if she had lost weight or gained weight. This citation relates to Complaint IN00463132.			
R 0275	Food and Nutritional Services - Deficiency 410 IAC 16.2-5-5.1(h) (h) Diet orders shall be reviewed and revised by the physician as the resident ' s condition requires. Based on observation, record review, and interview, the facility failed to ensure residents with significant weight loss were assessed and monitored to prevent further decline as well as ensuring the Registered	R 0275	It is the policy of this community to ensure residents with significant weight loss are assessed and monitored as well as ensuring the RD recommendations are acted upon in a timely manner. No adverse effects were noted for any resident involved in this deficient practice. An audit of all weights for every resident in the facility was completed. No other residents were affected by this deficient	08/08/2025

	Dietitian's (RD) recommendations were acted upon for 3 of 4 residents reviewed for weight loss. (Residents E, G, and F) Findings include: 1. During an observation of the breakfast meal at 9:00 a.m., Resident E was served a bowl of oatmeal by Dietary Cook 1. The bowl was placed in front of her and the silverware was still wrapped in the napkin. The Memory Care Director was the only staff member in the dining room at that time. She walked over to the resident, unwrapped the silverware and gave the resident a bite of the oatmeal. She then gave the spoon to the resident and she began to feed herself. At 9:20 a.m., she was served a plate of scrambled eggs, a sausage link and a cinnamon roll by Dietary Cook 1. She sat there and did not touch her food or attempt to feed herself. At 9:27 a.m., the Memory Care Director, who again was the only staff member in the dining room, gave her a new set of silverware, cut up her sausage link and gave her the fork to start feeding herself. During an observation of the lunch meal on 7/16/25 at 12:20 p.m., the resident was served a bowl of potato soup by Dietary Cook 1. She sat there and stared at the soup. At 12:24		practice. The DON/Designee will audit all weights by the 5th day of each month. The DON/Designee will notify the MD/RD of all significant weight changes and ensure that any new orders are placed in PCC as written by MD. The DON/Designee will audit all residents with weight changes weekly until resolved using the audit form indefinitely. All results will be reviewed during the monthly QA meeting.	

	p.m., the Memory Care Director unwrapped her silverware and handed her the spoon to eat the soup. At 12:44 p.m., the CNA served her a plate of pot roast, cabbage, potatoes, and a dinner roll. She put the plate in front of the resident and left, she offered no set up or cueing to eat. At 12:49 p.m., the CNA came back and offered to help the resident eat. The record for Resident E was reviewed on 7/16/25 at 12:08 p.m. Diagnoses included, but were not limited to, dementia, delusional disorder, and urge incontinence. A Service Plan, dated 6/30/24, indicated the resident required preparation of all meals. The resident weighed 162 pounds on 11/2/24 and 143 pounds on 5/9/25, which was a 19 pound weight loss in six months. There were no weights obtained in June or July 2025. A weight was requested and obtained on 7/16/25 and the resident weighed 139 pounds. A Physician's Order, dated 4/2/25, indicated to obtain a monthly weight.			

The Physician Order Statement, dated 7/2025, indicated the resident received a regular no added salt diet. There were no extra supplements ordered for the resident.

There were no Registered Dietitian (RD) progress notes to review. There was no documentation the resident's physician or the family was notified of the weight loss in the last six months.

During an interview on 7/16/25 at 3:15 p.m., the Director of Nursing (DON) indicated there were no RD or Physician progress notes regarding the weight loss.

During an interview on 7/16/25 at 4:20 p.m., the DON indicated the resident had no June or July weights obtained until requested that day.

2. The record for Resident G was reviewed on 7/16/25 at 11:00 a.m. Diagnoses included, but were not limited to, bipolar disorder, major depressive disorder, personality and behavioral disorder, chronic kidney disease, and insomnia.

A Service Plan, dated 7/12/24, indicated the resident needed to be reminded to go to meals.

The resident weighed 141 pounds on 12/5/25 and 129 pounds on 1/3/25. The resident

weighed 130 pounds on 4/3/25 and 119 pounds on 5/9/25. There were no weights obtained for 6/2025 and 7/2025. A weight was requested and obtained on 7/16/25 and the resident weighed 119 pounds.

A Physician's Order, dated 4/19/24, indicated the resident received a regular no added salt diet. There were no extra supplements ordered for the resident.

There were no Registered Dietitian (RD) progress notes to review. There was no documentation the resident's physician or the family was notified of the weight loss in the last six months.

During an interview on 7/16/25 at 3:10 p.m., the Director of Nursing (DON) indicated there were no RD or Physician progress notes regarding the weight loss.

During an interview on 7/16/25 at 4:20 p.m., the DON indicated the resident had no June or July weights obtained until that day.

3. The record for Resident F was reviewed on 7/16/25 at 12:02 p.m. Diagnoses included, but were not limited to, Alzheimer's disease, heart disease, and depression.

A Service Plan, last updated 6/26/25, indicated the resident

was not cognitively intact for daily decision making and required assistance with activities of daily living.

A 5/22/25 Dietary Note indicated the resident had a significant weight loss of 16% in 180 days and 28% over one year. The dietician recommended considering an appetite stimulant medication and reviewing other medications that may decrease her appetite as well as providing daily nutritional supplements between meals to assist with nutrient intake.

The record lacked documentation of initiation of an appetite stimulant, a review of medications that may decrease appetite, and provision of nutritional supplements.

During an interview on 7/16/25 at 3:26 p.m., the Director of Nursing (DON) indicated the dietician's recommendations should have been entered as orders by the previous DON, but she did not carry them out.

This citation relates to Complaint IN00463132.

Based on observation, record review, and interview, the facility failed to ensure residents with significant weight loss were assessed and monitored to prevent further decline as well as ensuring the Registered Dietitian's (RD)

recommendations were acted upon for 3 of 4 residents reviewed for weight loss. (Residents E, G, and F)

Findings include:

1. During an observation of the breakfast meal at 9:00 a.m., Resident E was served a bowl of oatmeal by Dietary Cook 1. The bowl was placed in front of her and the silverware was still wrapped in the napkin. The Memory Care Director was the only staff member in the dining room at that time. She walked over to the resident, unwrapped the silverware and gave the resident a bite of the oatmeal. She then gave the spoon to the resident and she began to feed herself. At 9:20 a.m., she was served a plate of scrambled eggs, a sausage link and a cinnamon roll by Dietary Cook 1. She sat there and did not touch her food or attempt to feed herself. At 9:27 a.m., the Memory Care Director, who again was the only staff member in the dining room, gave her a new set of silverware, cut up her sausage link and gave her the fork to start feeding herself.

During an observation of the lunch meal on 7/16/25 at 12:20 p.m., the resident was served a bowl of potato soup by Dietary Cook 1. She sat there and stared at the soup. At 12:24 p.m., the Memory Care Director

unwrapped her silverware and handed her the spoon to eat the soup. At 12:44 p.m., the CNA served her a plate of pot roast, cabbage, potatoes, and a dinner roll. She put the plate in front of the resident and left, she offered no set up or cueing to eat. At 12:49 p.m., the CNA came back and offered to help the resident eat.

The record for Resident E was reviewed on 7/16/25 at 12:08 p.m. Diagnoses included, but were not limited to, dementia, delusional disorder, and urge incontinence.

A Service Plan, dated 6/30/24, indicated the resident required preparation of all meals.

The resident weighed 162 pounds on 11/2/24 and 143 pounds on 5/9/25, which was a 19 pound weight loss in six months. There were no weights obtained in June or July 2025. A weight was requested and obtained on 7/16/25 and the resident weighed 139 pounds.

A Physician's Order, dated 4/2/25, indicated to obtain a monthly weight.

The Physician Order Statement, dated 7/2025, indicated the resident received a regular no added salt diet. There were no extra supplements ordered for the resident.

	There were no Registered Dietitian (RD) progress notes to review. There was no documentation the resident's physician or the family was notified of the weight loss in the last six months. During an interview on 7/16/25 at 3:15 p.m., the Director of Nursing (DON) indicated there were no RD or Physician progress notes regarding the weight loss. During an interview on 7/16/25 at 4:20 p.m., the DON indicated the resident had no June or July weights obtained until requested that day. 2. The record for Resident G was reviewed on 7/16/25 at 11:00 a.m. Diagnoses included, but were not limited to, bipolar disorder, major depressive disorder, personality and behavioral disorder, chronic kidney disease, and insomnia. A Service Plan, dated 7/12/24, indicated the resident needed to be reminded to go to meals.			

	The resident weighed 141 pounds on 12/5/25 and 129 pounds on 1/3/25. The resident weighed 130 pounds on 4/3/25 and 119 pounds on 5/9/25. There were no weights obtained for 6/2025 and 7/2025. A weight was requested and obtained on 7/16/25 and the resident weighed 119 pounds. A Physician's Order, dated 4/19/24, indicated the resident received a regular no added salt diet. There were no extra supplements ordered for the resident. There were no Registered Dietitian (RD) progress notes to review. There was no documentation the resident's physician or the family was notified of the weight loss in the last six months. During an interview on 7/16/25 at 3:10 p.m., the Director of Nursing (DON) indicated there were no RD or Physician progress notes regarding the weight loss. During an interview on 7/16/25 at 4:20 p.m., the DON indicated the resident had no June or July weights obtained until that day.			

	3. The record for Resident F was reviewed on 7/16/25 at 12:02 p.m. Diagnoses included, but were not limited to, Alzheimer's disease, heart disease, and depression. A Service Plan, last updated 6/26/25, indicated the resident was not cognitively intact for daily decision making and required assistance with activities of daily living. A 5/22/25 Dietary Note indicated the resident had a significant weight loss of 16% in 180 days and 28% over one year. The dietician recommended considering an appetite stimulant medication and reviewing other medications that may decrease her appetite as well as providing daily nutritional supplements between meals to assist with nutrient intake. The record lacked documentation of initiation of an appetite stimulant, a review of medications that may decrease appetite, and provision of nutritional supplements. During an interview on 7/16/25 at 3:26 p.m., the Director of Nursing (DON) indicated the dietician's recommendations should have been entered as orders by the previous DON, but she did not carry them out.			

This citation relates to Complaint IN00463132.

Based on observation, record review, and interview, the facility failed to ensure residents with significant weight loss were assessed and monitored to prevent further decline as well as ensuring the Registered Dietitian's (RD) recommendations were acted upon for 3 of 4 residents reviewed for weight loss. (Residents E, G, and F)

Findings include:

1. During an observation of the breakfast meal at 9:00 a.m., Resident E was served a bowl of oatmeal by Dietary Cook 1. The bowl was placed in front of her and the silverware was still wrapped in the napkin. The Memory Care Director was the only staff member in the dining room at that time. She walked over to the resident, unwrapped the silverware and gave the resident a bite of the oatmeal. She then gave the spoon to the resident and she began to feed herself. At 9:20 a.m., she was served a plate of scrambled eggs, a sausage link and a cinnamon roll by Dietary Cook 1. She sat there and did not touch her food or attempt to feed herself. At 9:27 a.m., the Memory Care Director, who again was the only staff member in the dining room, gave her a

new set of silverware, cut up her sausage link and gave her the fork to start feeding herself.

During an observation of the lunch meal on 7/16/25 at 12:20 p.m., the resident was served a bowl of potato soup by Dietary Cook 1. She sat there and stared at the soup. At 12:24 p.m., the Memory Care Director unwrapped her silverware and handed her the spoon to eat the soup. At 12:44 p.m., the CNA served her a plate of pot roast, cabbage, potatoes, and a dinner roll. She put the plate in front of the resident and left, she offered no set up or cueing to eat. At 12:49 p.m., the CNA came back and offered to help the resident eat.

The record for Resident E was reviewed on 7/16/25 at 12:08 p.m. Diagnoses included, but were not limited to, dementia, delusional disorder, and urge incontinence.

A Service Plan, dated 6/30/24, indicated the resident required preparation of all meals.

The resident weighed 162 pounds on 11/2/24 and 143 pounds on 5/9/25, which was a 19 pound weight loss in six months. There were no weights obtained in June or July 2025. A weight was requested and obtained on 7/16/25 and the resident weighed 139 pounds.

	A Physician's Order, dated 4/2/25, indicated to obtain a monthly weight. The Physician Order Statement, dated 7/2025, indicated the resident received a regular no added salt diet. There were no extra supplements ordered for the resident. There were no Registered Dietitian (RD) progress notes to review. There was no documentation the resident's physician or the family was notified of the weight loss in the last six months. During an interview on 7/16/25 at 3:15 p.m., the Director of Nursing (DON) indicated there were no RD or Physician progress notes regarding the weight loss. During an interview on 7/16/25 at 4:20 p.m., the DON indicated the resident had no June or July weights obtained until requested that day. 2. The record for Resident G was reviewed on 7/16/25 at 11:00 a.m. Diagnoses included, but were not limited to, bipolar disorder, major depressive disorder, personality and behavioral disorder, chronic kidney disease, and insomnia.			

A Service Plan, dated 7/12/24, indicated the resident needed to be reminded to go to meals.

The resident weighed 141 pounds on 12/5/25 and 129 pounds on 1/3/25. The resident weighed 130 pounds on 4/3/25 and 119 pounds on 5/9/25. There were no weights obtained for 6/2025 and 7/2025. A weight was requested and obtained on 7/16/25 and the resident weighed 119 pounds.

A Physician's Order, dated 4/19/24, indicated the resident received a regular no added salt diet. There were no extra supplements ordered for the resident.

There were no Registered Dietitian (RD) progress notes to review. There was no documentation the resident's physician or the family was notified of the weight loss in the last six months.

During an interview on 7/16/25 at 3:10 p.m., the Director of Nursing (DON) indicated there were no RD or Physician progress notes regarding the weight loss.

During an interview on 7/16/25 at 4:20 p.m., the DON indicated the resident had no June or July weights obtained until that day.

3. The record for Resident F was reviewed on 7/16/25 at

12:02 p.m. Diagnoses included, but were not limited to, Alzheimer's disease, heart disease, and depression.

A Service Plan, last updated 6/26/25, indicated the resident was not cognitively intact for daily decision making and required assistance with activities of daily living.

A 5/22/25 Dietary Note indicated the resident had a significant weight loss of 16% in 180 days and 28% over one year. The dietician recommended considering an appetite stimulant medication and reviewing other medications that may decrease her appetite as well as providing daily nutritional supplements between meals to assist with nutrient intake.

The record lacked documentation of initiation of an appetite stimulant, a review of medications that may decrease appetite, and provision of nutritional supplements.

During an interview on 7/16/25 at 3:26 p.m., the Director of Nursing (DON) indicated the dietician's recommendations should have been entered as orders by the previous DON, but she did not carry them out.

This citation relates to Complaint IN00463132.

Based on observation, record

	review, and interview, the facility failed to ensure residents with significant weight loss were assessed and monitored to prevent further decline as well as ensuring the Registered Dietitian's (RD) recommendations were acted upon for 3 of 4 residents reviewed for weight loss. (Residents E, G, and F) Findings include: 1. During an observation of the breakfast meal at 9:00 a.m., Resident E was served a bowl of oatmeal by Dietary Cook 1. The bowl was placed in front of her and the silverware was still wrapped in the napkin. The Memory Care Director was the only staff member in the dining room at that time. She walked over to the resident, unwrapped the silverware and gave the resident a bite of the oatmeal. She then gave the spoon to the resident and she began to feed herself. At 9:20 a.m., she was served a plate of scrambled eggs, a sausage link and a cinnamon roll by Dietary Cook 1. She sat there and did not touch her food or attempt to feed herself. At 9:27 a.m., the Memory Care Director, who again was the only staff member in the dining room, gave her a new set of silverware, cut up her sausage link and gave her the fork to start feeding herself.			

During an observation of the lunch meal on 7/16/25 at 12:20 p.m., the resident was served a bowl of potato soup by Dietary Cook 1. She sat there and stared at the soup. At 12:24 p.m., the Memory Care Director unwrapped her silverware and handed her the spoon to eat the soup. At 12:44 p.m., the CNA served her a plate of pot roast, cabbage, potatoes, and a dinner roll. She put the plate in front of the resident and left, she offered no set up or cueing to eat. At 12:49 p.m., the CNA came back and offered to help the resident eat.

The record for Resident E was reviewed on 7/16/25 at 12:08 p.m. Diagnoses included, but were not limited to, dementia, delusional disorder, and urge incontinence.

A Service Plan, dated 6/30/24, indicated the resident required preparation of all meals.

The resident weighed 162 pounds on 11/2/24 and 143 pounds on 5/9/25, which was a 19 pound weight loss in six months. There were no weights obtained in June or July 2025. A weight was requested and obtained on 7/16/25 and the resident weighed 139 pounds.

A Physician's Order, dated 4/2/25, indicated to obtain a monthly weight.

The Physician Order Statement, dated 7/2025, indicated the resident received a regular no added salt diet. There were no extra supplements ordered for the resident.

There were no Registered Dietitian (RD) progress notes to review. There was no documentation the resident's physician or the family was notified of the weight loss in the last six months.

During an interview on 7/16/25 at 3:15 p.m., the Director of Nursing (DON) indicated there were no RD or Physician progress notes regarding the weight loss.

During an interview on 7/16/25 at 4:20 p.m., the DON indicated the resident had no June or July weights obtained until requested that day.

2. The record for Resident G was reviewed on 7/16/25 at 11:00 a.m. Diagnoses included, but were not limited to, bipolar disorder, major depressive disorder, personality and behavioral disorder, chronic kidney disease, and insomnia.

A Service Plan, dated 7/12/24, indicated the resident needed to be reminded to go to meals.

The resident weighed 141 pounds on 12/5/25 and 129 pounds on 1/3/25. The resident

weighed 130 pounds on 4/3/25 and 119 pounds on 5/9/25. There were no weights obtained for 6/2025 and 7/2025. A weight was requested and obtained on 7/16/25 and the resident weighed 119 pounds.

A Physician's Order, dated 4/19/24, indicated the resident received a regular no added salt diet. There were no extra supplements ordered for the resident.

There were no Registered Dietitian (RD) progress notes to review. There was no documentation the resident's physician or the family was notified of the weight loss in the last six months.

During an interview on 7/16/25 at 3:10 p.m., the Director of Nursing (DON) indicated there were no RD or Physician progress notes regarding the weight loss.

During an interview on 7/16/25 at 4:20 p.m., the DON indicated the resident had no June or July weights obtained until that day.

3. The record for Resident F was reviewed on 7/16/25 at 12:02 p.m. Diagnoses included, but were not limited to, Alzheimer's disease, heart disease, and depression.

A Service Plan, last updated 6/26/25, indicated the resident

	was not cognitively intact for daily decision making and required assistance with activities of daily living. A 5/22/25 Dietary Note indicated the resident had a significant weight loss of 16% in 180 days and 28% over one year. The dietician recommended considering an appetite stimulant medication and reviewing other medications that may decrease her appetite as well as providing daily nutritional supplements between meals to assist with nutrient intake. The record lacked documentation of initiation of an appetite stimulant, a review of medications that may decrease appetite, and provision of nutritional supplements. During an interview on 7/16/25 at 3:26 p.m., the Director of Nursing (DON) indicated the dietician's recommendations should have been entered as orders by the previous DON, but she did not carry them out. This citation relates to Complaint IN00463132.			
R 0305	Pharmaceutical Services - Noncompliance 410 IAC 16.2-5-6(f)(1-3) (f) Residents may use the pharmacy of their choice for	R 0305	It is the policy of this community to ensure medications are provided by the pharmacy in a timely manner. An audit of the EMAR/charting/pending orders was completed to ensure no	08/08/2025

	medications administered by the facility, as long as the pharmacy: (1) complies with the facility policy receiving, packaging, and labeling of pharmaceutical products unless contrary to state and federal laws; (2) provides prescribed service on a prompt and timely basis; and (3) refills prescription drugs when needed, in order to prevent interruption of drug regimens. Based on record review and interview, the facility failed to ensure medications were provided by the pharmacy in a prompt and timely manner for 2 of 3 residents reviewed for medications. (Residents H and E) Findings include: 1. The record for Resident H was reviewed on 7/16/25 at 3:00 p.m. Diagnoses included, but were not limited to, post traumatic osteoarthritis of hip, depression, arthritis, and high blood pressure. A Physician's Order, dated 5/3/25, indicated Hydrocodone (a narcotic medication used for pain) 5-325 milligrams give one tablet at bed time. The Medication Administration Record (MAR) for 7/2025 indicated the medication was signed out as not being		other residents were missing medications. The DON/Designee will audit the EMAR/ progress notes/pending orders using the audit form. Audits will be completed 3 times per week for 3 months, then twice per week for 2 months, then weekly indefinitely. All results will be reviewed during our monthly QA meeting.	

available on 7/10/25, 7/11/25, 7/12/25, 7/13/25, and 7/14/25.

A Nurse's Note, dated 7/10/25 at 9:48 p.m., indicated staff notified the Nurse Practitioner of the need for another prescription for the Hydrocodone.

Nurses' Notes, dated 7/12/25, 7/13/25, and 7/14/25 indicated the facility was waiting on the pharmacy for the Hydrocodone medication.

During an interview on 7/16/25 at 3:25 p.m., the Director of Nursing indicated nursing staff should have called the pharmacy and not put "not available" on the MAR.

2. The record for Resident E was reviewed on 7/16/25 at 12:08 p.m. Diagnoses included, but were not limited to, dementia, delusional disorder, and urge incontinence.

A Nurse's Note, dated 7/11/25 at 6:19 p.m., indicated the resident was observed with bright blood with clots from the rectum while defecating. The blood was dripping from the rectum continuously and a hemorrhoid was also observed. The Physician was notified and orders to send the resident to the emergency room were obtained.

A Nurse's Note, dated 7/11/25

at 10:27 p.m., indicated the resident would be returning to the facility with the diagnosis of a urinary tract infection.

A Physician's Order, dated 7/11/25, indicated Cephalexin (an antibiotic) 500 milligrams (mg), give one capsule every morning and at bed time for five days.

A Physician's Order, dated 7/11/25, indicated HC Pramoxine cream 2.5-1% (a hemorrhoid cream), insert rectally three times a day for 10 days.

The Medication Administration Record for 7/2025 indicated the Cephalexin and the Pramoxine cream were not administered on 7/12 and 7/13/25. The Pramoxine cream was coded as not available on 7/14/25, on 7/15/25 for the 8:00 p.m. dose., and on 7/16/25 for the 8:00 a.m. and 12:00 p.m. doses.

Nurse's Notes, dated 7/14/25 and 7/16/25, indicated the facility was awaiting the delivery of the Pramoxine cream from the pharmacy.

During an interview on 7/16/25 at 4:20 p.m., the Director of Nursing indicated nursing staff should have called the pharmacy to see what the issue was for the medications.

This citation relates to

Complaint IN00463417.

Based on record review and interview, the facility failed to ensure medications were provided by the pharmacy in a prompt and timely manner for 2 of 3 residents reviewed for medications. (Residents H and E)

Findings include:

1. The record for Resident H was reviewed on 7/16/25 at 3:00 p.m. Diagnoses included, but were not limited to, post traumatic osteoarthritis of hip, depression, arthritis, and high blood pressure.

A Physician's Order, dated 5/3/25, indicated Hydrocodone (a narcotic medication used for pain) 5-325 milligrams give one tablet at bed time.

The Medication Administration Record (MAR) for 7/2025 indicated the medication was signed out as not being available on 7/10/25, 7/11/25, 7/12/25, 7/13/25, and 7/14/25.

A Nurse's Note, dated 7/10/25 at 9:48 p.m., indicated staff notified the Nurse Practitioner of the need for another prescription for the Hydrocodone.

Nurses' Notes, dated 7/12/25, 7/13/25, and 7/14/25 indicated the facility was waiting on the

pharmacy for the Hydrocodone medication.

During an interview on 7/16/25 at 3:25 p.m., the Director of Nursing indicated nursing staff should have called the pharmacy and not put "not available" on the MAR.

2. The record for Resident E was reviewed on 7/16/25 at 12:08 p.m. Diagnoses included, but were not limited to, dementia, delusional disorder, and urge incontinence.

A Nurse's Note, dated 7/11/25 at 6:19 p.m., indicated the resident was observed with bright blood with clots from the rectum while defecating. The blood was dripping from the rectum continuously and a hemorrhoid was also observed. The Physician was notified and orders to send the resident to the emergency room were obtained.

A Nurse's Note, dated 7/11/25 at 10:27 p.m., indicated the resident would be returning to the facility with the diagnosis of a urinary tract infection.

A Physician's Order, dated 7/11/25, indicated Cephalexin (an antibiotic) 500 milligrams (mg), give one capsule every morning and at bed time for five days.

A Physician's Order, dated

	7/11/25, indicated HC Pramoxine cream 2.5-1% (a hemorrhoid cream), insert rectally three times a day for 10 days. The Medication Administration Record for 7/2025 indicated the Cephalexin and the Pramoxine cream were not administered on 7/12 and 7/13/25. The Pramoxine cream was coded as not available on 7/14/25, on 7/15/25 for the 8:00 p.m. dose., and on 7/16/25 for the 8:00 a.m. and 12:00 p.m. doses. Nurse's Notes, dated 7/14/25 and 7/16/25, indicated the facility was awaiting the delivery of the Pramoxine cream from the pharmacy. During an interview on 7/16/25 at 4:20 p.m., the Director of Nursing indicated nursing staff should have called the pharmacy to see what the issue was for the medications. This citation relates to Complaint IN00463417.			
R 0349	Clinical Records - Noncompliance 410 IAC 16.2-5-8.1(a)(1-4) (a) The facility must maintain clinical records on each resident. These records must be maintained under the supervision of an employee of the facility designated with that responsibility. The records	R 0349	It is the policy of this community to ensure clinical records are complete and accurately documented. No adverse effects were noted for any resident involved in this deficient practice. No other residents were affected. The DON/Designee	08/08/2025

	must be as follows: (1) Complete. (2) Accurately documented. (3) Readily accessible. (4) Systematically organized. Based on record review and interview, the facility failed to ensure clinical records were complete and accurately documented related to follow up documentation after a resident to resident altercation for 2 of 3 residents reviewed for allegations of abuse. (Residents C and G) Findings include: 1. The record for Resident C was reviewed on 7/16/25 at 12:26 p.m. Diagnoses included, but were not limited to, dementia without behavior disturbance and major depressive disorder. An Incident Report, dated 7/2/25 at 6:30 p.m., indicated Resident C was in the kitchenette area making popcorn when she was approached by Resident B. Due to a previous incident, Resident C tried to walk away from Resident B without speaking. Resident B then started pushing Resident C into the counter top. Resident C was able to get away from the resident and she		will audit all charting using an audit form. Charting audits will be completed 3 times per week for 3 months, then 2 times per week for 2 months, then weekly for 1 month. All results will be reviewed during our monthly QA meeting.	

proceeded to call the police. Resident C notified the nursing staff after calling the police.

There was no documentation of the incident in the nursing progress notes on 7/2/25. There was also no follow up documentation regarding the incident.

During an interview on 7/16/25 at 3:10 p.m., the Director of Nursing (DON) indicated the incident should have been documented in the nursing progress notes and alert charting should have been completed. The DON indicated "alert charting" meant nursing staff were to document on the resident every shift for 72 hours.

2. The record for Resident G was reviewed on 7/16/25 at 11:00 a.m. Diagnoses included, but were not limited to, bipolar disorder, major depressive disorder, personality and behavioral disorder, chronic kidney disease, and insomnia.

A Nurse's Note, dated 7/4/25 at 2:20 p.m., indicated the resident kicked another resident in the face when the resident was wheeling past her in a wheelchair. The resident was removed from the lounge area and taken back to her room.

A Nurse's Note, dated 7/4/25 at 2:51 p.m., indicated the resident was wearing non skid socks and

not shoes to both feet. At 3:02 p.m., the resident's daughter was notified.

The next entry in the Nurses' Notes was on 7/5/25 at 10:53 p.m., which indicated the resident had no behaviors.

The next entry in Nurses' Notes was on 7/6/25 at 11:56 a.m., which indicated the resident had no behaviors.

The next entry in Nurses' Notes was on 7/10/25 at 11:53 a.m., which indicated the physician was in the facility and assessed the resident.

There was no continuous documentation of the resident's behaviors for 72 hours every shift after the incident.

The incident, dated 7/5/25, indicated Resident G kicked another resident in the face. Both residents were immediately separated and assessed for injury, which none was noted. Both residents were placed on increased safety checks and alert charting.

During an interview on 7/16/25 at 3:10 p.m., the Director of Nursing indicated "alert charting" meant nursing staff were to document on the resident every shift for 72 hours.

This citation relates to Complaint IN00462838.

Based on record review and interview, the facility failed to ensure clinical records were complete and accurately documented related to follow up documentation after a resident to resident altercation for 2 of 3 residents reviewed for allegations of abuse. (Residents C and G)

Findings include:

1. The record for Resident C was reviewed on 7/16/25 at 12:26 p.m. Diagnoses included, but were not limited to, dementia without behavior disturbance and major depressive disorder.

An Incident Report, dated 7/2/25 at 6:30 p.m., indicated Resident C was in the kitchenette area making popcorn when she was approached by Resident B. Due to a previous incident, Resident C tried to walk away from Resident B without speaking. Resident B then started pushing Resident C into the counter top. Resident C was able to get away from the resident and she proceeded to call the police. Resident C notified the nursing staff after calling the police.

There was no documentation of the incident in the nursing progress notes on 7/2/25. There

was also no follow up documentation regarding the incident.

During an interview on 7/16/25 at 3:10 p.m., the Director of Nursing (DON) indicated the incident should have been documented in the nursing progress notes and alert charting should have been completed. The DON indicated "alert charting" meant nursing staff were to document on the resident every shift for 72 hours.

2. The record for Resident G was reviewed on 7/16/25 at 11:00 a.m. Diagnoses included, but were not limited to, bipolar disorder, major depressive disorder, personality and behavioral disorder, chronic kidney disease, and insomnia.

A Nurse's Note, dated 7/4/25 at 2:20 p.m., indicated the resident kicked another resident in the face when the resident was wheeling past her in a wheelchair. The resident was removed from the lounge area and taken back to her room.

A Nurse's Note, dated 7/4/25 at 2:51 p.m., indicated the resident was wearing non skid socks and not shoes to both feet. At 3:02 p.m., the resident's daughter was notified.

The next entry in the Nurses' Notes was on 7/5/25 at 10:53 p.m., which indicated the

resident had no behaviors.

The next entry in Nurses' Notes was on 7/6/25 at 11:56 a.m., which indicated the resident had no behaviors.

The next entry in Nurses' Notes was on 7/10/25 at 11:53 a.m., which indicated the physician was in the facility and assessed the resident.

There was no continuous documentation of the resident's behaviors for 72 hours every shift after the incident.

The incident, dated 7/5/25, indicated Resident G kicked another resident in the face. Both residents were immediately separated and assessed for injury, which none was noted. Both residents were placed on increased safety checks and alert charting.

During an interview on 7/16/25 at 3:10 p.m., the Director of Nursing indicated "alert charting" meant nursing staff were to document on the resident every shift for 72 hours.

This citation relates to Complaint IN00462838.

Based on record review and interview, the facility failed to ensure clinical records were complete and accurately documented related to follow up documentation after a resident

to resident altercation for 2 of 3 residents reviewed for allegations of abuse. (Residents C and G)

Findings include:

1. The record for Resident C was reviewed on 7/16/25 at 12:26 p.m. Diagnoses included, but were not limited to, dementia without behavior disturbance and major depressive disorder.

An Incident Report, dated 7/2/25 at 6:30 p.m., indicated Resident C was in the kitchenette area making popcorn when she was approached by Resident B. Due to a previous incident, Resident C tried to walk away from Resident B without speaking. Resident B then started pushing Resident C into the counter top. Resident C was able to get away from the resident and she proceeded to call the police. Resident C notified the nursing staff after calling the police.

There was no documentation of the incident in the nursing progress notes on 7/2/25. There was also no follow up documentation regarding the incident.

During an interview on 7/16/25 at 3:10 p.m., the Director of Nursing (DON) indicated the incident should have been documented in the nursing

progress notes and alert charting should have been completed. The DON indicated "alert charting" meant nursing staff were to document on the resident every shift for 72 hours.

2. The record for Resident G was reviewed on 7/16/25 at 11:00 a.m. Diagnoses included, but were not limited to, bipolar disorder, major depressive disorder, personality and behavioral disorder, chronic kidney disease, and insomnia.

A Nurse's Note, dated 7/4/25 at 2:20 p.m., indicated the resident kicked another resident in the face when the resident was wheeling past her in a wheelchair. The resident was removed from the lounge area and taken back to her room.

A Nurse's Note, dated 7/4/25 at 2:51 p.m., indicated the resident was wearing non skid socks and not shoes to both feet. At 3:02 p.m., the resident's daughter was notified.

The next entry in the Nurses' Notes was on 7/5/25 at 10:53 p.m., which indicated the resident had no behaviors.

The next entry in Nurses' Notes was on 7/6/25 at 11:56 a.m., which indicated the resident had no behaviors.

The next entry in Nurses' Notes was on 7/10/25 at 11:53 a.m.,

which indicated the physician was in the facility and assessed the resident.

There was no continuous documentation of the resident's behaviors for 72 hours every shift after the incident.

The incident, dated 7/5/25, indicated Resident G kicked another resident in the face. Both residents were immediately separated and assessed for injury, which none was noted. Both residents were placed on increased safety checks and alert charting.

During an interview on 7/16/25 at 3:10 p.m., the Director of Nursing indicated "alert charting" meant nursing staff were to document on the resident every shift for 72 hours.

This citation relates to Complaint IN00462838.

Based on record review and interview, the facility failed to ensure clinical records were complete and accurately documented related to follow up documentation after a resident to resident altercation for 2 of 3 residents reviewed for allegations of abuse. (Residents C and G)

Findings include:

1. The record for Resident C was reviewed on 7/16/25 at

12:26 p.m. Diagnoses included, but were not limited to, dementia without behavior disturbance and major depressive disorder.

An Incident Report, dated 7/2/25 at 6:30 p.m., indicated Resident C was in the kitchenette area making popcorn when she was approached by Resident B. Due to a previous incident, Resident C tried to walk away from Resident B without speaking. Resident B then started pushing Resident C into the counter top. Resident C was able to get away from the resident and she proceeded to call the police. Resident C notified the nursing staff after calling the police.

There was no documentation of the incident in the nursing progress notes on 7/2/25. There was also no follow up documentation regarding the incident.

During an interview on 7/16/25 at 3:10 p.m., the Director of Nursing (DON) indicated the incident should have been documented in the nursing progress notes and alert charting should have been completed. The DON indicated "alert charting" meant nursing staff were to document on the resident every shift for 72 hours.

2. The record for Resident G

was reviewed on 7/16/25 at 11:00 a.m. Diagnoses included, but were not limited to, bipolar disorder, major depressive disorder, personality and behavioral disorder, chronic kidney disease, and insomnia.

A Nurse's Note, dated 7/4/25 at 2:20 p.m., indicated the resident kicked another resident in the face when the resident was wheeling past her in a wheelchair. The resident was removed from the lounge area and taken back to her room.

A Nurse's Note, dated 7/4/25 at 2:51 p.m., indicated the resident was wearing non skid socks and not shoes to both feet. At 3:02 p.m., the resident's daughter was notified.

The next entry in the Nurses' Notes was on 7/5/25 at 10:53 p.m., which indicated the resident had no behaviors.

The next entry in Nurses' Notes was on 7/6/25 at 11:56 a.m., which indicated the resident had no behaviors.

The next entry in Nurses' Notes was on 7/10/25 at 11:53 a.m., which indicated the physician was in the facility and assessed the resident.

	There was no continuous documentation of the resident's behaviors for 72 hours every shift after the incident. The incident, dated 7/5/25, indicated Resident G kicked another resident in the face. Both residents were immediately separated and assessed for injury, which none was noted. Both residents were placed on increased safety checks and alert charting. During an interview on 7/16/25 at 3:10 p.m., the Director of Nursing indicated "alert charting" meant nursing staff were to document on the resident every shift for 72 hours. This citation relates to Complaint IN00462838.			

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting provided it is determined that other safeguards provide sufficient protection to the patients. (See instructions.)

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