

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 12/27/2024	
NAME OF PROVIDER OR SUPPLIER BRENTWOOD AT HOBART		STREET ADDRESS, CITY, STATE, ZIP CODE 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 IN00448513, IN00448580, IN00448935 and IN00449809. Complaint IN00448513 - No deficiencies related to the allegations are cited. Complaint IN00448580 - State deficiencies related to the allegations are cited at R0064 and R0349. Complaint IN00448935 - State deficiency related to the allegations is cited at R0045. Complaint IN00449809 - State deficiency related to the allegations is cited at R0045. Survey dates: December 26 and 27, 2024 Facility number: 002627 Residential Census: 111 These State Residential Findings are cited in accordance	R 0000	Submission of this plan of correction by Brentwood at Hobart is not a legal admission that a deficiency exists or that the listed deficiencies were correctly cited. In addition, the preparation and submission of this POC does not constitute an admission or agreement of any kind by the facility of the truth of any facts set forth in this allegation by the survey agency. Measures the facility will take or systems the facility will alter to ensure that the problem will be corrected and will not recur is no admission of deficiency. All facility residents have the potential to be affected by the alleged deficient practice.				

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	with 410 IAC 16.2-5. Quality review completed on 1/6/25.			
R 0045	Residents' Rights - Deficiency 410 IAC 16.2-5-1.2(r)(6-9) (6) Before an interfacility transfer or discharge occurs, the facility must, on a form prescribed by the department, do the following: (A) Notify the resident of the transfer or discharge and the reasons for the move, in writing, and in a language and manner that the resident understands. The health facility must place a copy of the notice in the resident ' s clinical record and transmit a copy to the following: (i) The resident. (ii) A family member of the resident if known. (iii) The resident ' s legal representative if known. (iv) The local long term care ombudsman program (for involuntary relocations or discharges only). (v) The person or agency responsible for the resident ' s placement, maintenance, and care in the facility. (vi) In situations where the resident is developmentally disabled, the regional office of the division of disability, aging, and rehabilitative	R 0045	This Plan of Correction is not to be construed as an admission of, or agreement with the findings and conclusions in the statement of deficiencies. This Plan of Correction is being submitted as required by the regulation. All residents have the potential to be affected by the deficient practice. The DON and Executive Director performed a review of the transfer/discharge policy and procedure including the completion of the transfer/discharge form, notice of transfer/discharge, and notice of transfer/discharge request for hearing. All transfer/discharge documents will be provided to each resident, POA, and/or responsible party prior to each transfer or discharge and entered into the resident's EHR. The DON, Executive Director, and/or designee will create a binder for each resident transfer or discharge and a copy will be recorded in the resident's EHR. The DON, Executive Director	01/27/2025

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	services, who may assist with placement decisions. (vii) The resident ' s physician when the transfer or discharge is necessary under subdivision (4)(C), (4)(D), (4)(E), or (4)(F). (B) Record the reasons in the resident ' s clinical record. (C) Include in the notice the items described in subdivision (9). (7) Except when specified in subdivision (8), the notice of transfer or discharge required under subdivision (6) must be made by the facility at least thirty (30) days before the resident is transferred or discharged. (8) Notice may be made as soon as practicable before transfer or discharge when: (A) the safety of individuals in the facility would be endangered; (B) the health of individuals in the facility would be endangered; (C) the resident ' s health improves sufficiently to allow a more immediate transfer or discharge; (D) an immediate transfer or discharge is required by the resident ' s urgent medical needs; or (E) a resident has not resided in the facility for thirty (30) days. (9) For health facilities, the written notice specified in subdivision (7) must include the following:		and/or designee will monitor this binder each month indefinitely to ensure completion and that proper documentation is obtained. Any transfers or discharges will be discussed monthly with the QAPI Committee.	
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(A) The reason for transfer or discharge.

(B) The effective date of transfer or discharge.

(C) The location to which the resident is transferred or discharged.

(D) A statement in not smaller than 12-point bold type that reads, " You have the right to appeal the health facility ' s decision to transfer you. If you think you should not have to leave this facility, you may file a written request for a hearing with the Indiana state department of health postmarked within ten (10) days after you receive this notice. If you request a hearing, it will be held within twenty-three (23) days after you receive this notice, and you will not be transferred from the facility earlier than thirty-four (34) days after you receive this notice of transfer or discharge unless the facility is authorized to transfer you under subdivision (8). If you wish to appeal this transfer or discharge, a form to appeal the health facility's decision and to request a hearing is attached. If you have any questions, call the Indiana state department of health at the number listed below. " .

(E) The name of the director and the address, telephone number, and hours of operation of the division.

(F) A hearing request form prescribed by the department.

(G) The name, address, and telephone number of the state and

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local long term care ombudsman.

(H) For health facility residents with developmental disabilities or who are mentally ill, the mailing address and telephone number of the protection and advocacy services commission.

Based on record review and interview, the facility failed to ensure resident's transfer and discharge rights were implemented related to not providing required documentation or paperwork for pending discharges for 3 of 3 residents reviewed for transfer and discharge. (Residents B, C and D)

Findings include:

1. During a telephone interview on 12/26/24 at 10:40 a.m., the resident's daughter indicated she received a letter from the facility on 11/26/24 stating that the resident would be discharged in 30 days. The letter was titled a Priority Life Care Discharge Notice. The family had not been provided information how to appeal the discharge.

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	Resident B's record was reviewed on 12/26/24 at 2:08 p.m. Diagnoses included, but were limited to, Alzheimer's dementia, hearing loss and depression. The resident resided on the locked memory care unit. Resident B's record lacked documentation of any pending discharge, reason for discharge or copies of Notice of Transfer or Discharge and Appeals Rights. 2. Resident C's record was reviewed on 12/26/24 at 1:05 p.m. Diagnoses included, but were not limited to, hypertension and anxiety.			
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During an interview on 12/27/24 at 9:15 a.m., the resident provided a copies of letters, titled Priority Life Care Discharge Notice, which she received on 11/26/24 indicating that her and her husband, Resident D, would be discharged on 12/26/24. She indicated no one at the facility had spoken to her about the discharge prior to receiving the letters. She and her husband had applied for a waiver to remain at the facility. She had requested Appeal Rights information from the Administrator and had received it after a long delay. There was an upcoming appeals hearing scheduled.

The resident's record lacked documentation of pending discharge, reason for discharge or copies of Notice of Transfer or Discharge and Appeals Rights.

3. Resident D's record was reviewed on 12/26/24 at 10:43 a.m. Diagnoses included, but were not limited to, unspecified dementia and hypothyroidism. He resided on the locked memory care unit.

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The resident's record lacked documentation of pending discharge, reason for discharge or copies of Notice of Transfer or Discharge and Appeals Rights.

During an interview on 12/26/24 at 1:10 p.m., the Clinical Operations Specialist indicated the former Administrator had issued discharge notices to four residents, including Residents B, C and D, for non-payment. They did not know what forms had been issued, so they were getting ready to start the discharge process over. She was unaware of the upcoming appeals hearing for Residents C and D.

During an interview on 12/26/24 at 2:42 p.m., the Business Office Manager provided copies of forms that should be provided to residents for any pending discharge. Forms included the Notice of Transfer or Discharge and the Appeals Rights. She indicated the three residents had applied for waivers, but had not been approved yet. She did not know what the previous Administrator had given to the residents for discharge notice.

The policy, "Termination of Residency", dated as reviewed 5/30/24, indicated, "...When the facility proposes to transfer or discharge a resident under any circumstances mentioned

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above, the resident's clinical record must be documented....". The required forms are Notice of Transfer Discharge and Notice of Transfer Discharge Request for Hearing.

This citation relates to Complaints IN00448935 and IN00449809.

Based on record review and interview, the facility failed to ensure resident's transfer and discharge rights were implemented related to not providing required documentation or paperwork for pending discharges for 3 of 3 residents reviewed for transfer and discharge. (Residents B, C and D)

Findings include:

1. During a telephone interview on 12/26/24 at 10:40 a.m., the resident's daughter indicated she received a letter from the facility on 11/26/24 stating that the resident would be discharged in 30 days. The letter was titled a Priority Life Care Discharge Notice. The family had not been provided information how to appeal the discharge.

Resident B's record was reviewed on 12/26/24 at 2:08 p.m. Diagnoses included, but were limited to, Alzheimer's dementia, hearing loss and depression. The resident

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resided on the locked memory care unit.

Resident B's record lacked documentation of any pending discharge, reason for discharge or copies of Notice of Transfer or Discharge and Appeals Rights.

2. Resident C's record was reviewed on 12/26/24 at 1:05 p.m. Diagnoses included, but were not limited to, hypertension and anxiety.

During an interview on 12/27/24 at 9:15 a.m., the resident provided a copies of letters, titled Priority Life Care Discharge Notice, which she received on 11/26/24 indicating that her and her husband, Resident D, would be discharged on 12/26/24. She indicated no one at the facility had spoken to her about the discharge prior to receiving the letters. She and her husband had applied for a waiver to remain at the facility. She had requested Appeal Rights information from the Administrator and had received it after a long delay. There was an upcoming appeals hearing scheduled.

The resident's record lacked documentation of pending discharge, reason for discharge or copies of Notice of Transfer or Discharge and Appeals

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Rights.

3. Resident D's record was reviewed on 12/26/24 at 10:43 a.m. Diagnoses included, but were not limited to, unspecified dementia and hypothyroidism. He resided on the locked memory care unit.

The resident's record lacked documentation of pending discharge, reason for discharge or copies of Notice of Transfer or Discharge and Appeals Rights.

During an interview on 12/26/24 at 1:10 p.m., the Clinical Operations Specialist indicated the former Administrator had issued discharge notices to four residents, including Residents B, C and D, for non-payment. They did not know what forms had been issued, so they were getting ready to start the discharge process over. She was unaware of the upcoming appeals hearing for Residents C and D.

During an interview on 12/26/24 at 2:42 p.m., the Business Office Manager provided copies of forms that should be provided to residents for any pending discharge. Forms included the Notice of Transfer or Discharge and the Appeals Rights. She indicated the three residents had applied for waivers, but had not been approved yet. She did

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	not know what the previous Administrator had given to the residents for discharge notice. The policy, "Termination of Residency", dated as reviewed 5/30/24, indicated, "...When the facility proposes to transfer or discharge a resident under any circumstances mentioned above, the resident's clinical record must be documented....". The required forms are Notice of Transfer Discharge and Notice of Transfer Discharge Request for Hearing. This citation relates to Complaints IN00448935 and IN00449809.			
R 0064	Residents' Rights- Noncompliance 410 IAC 16.2-5-1.2(hh) (hh) The facility shall exercise reasonable care for the protection of residents ' property from loss and theft. The administrator or his or her designee is responsible for investigating reports of lost or stolen resident property and that the results of the investigation are reported to the resident.	R 0064	Correction: The DON will complete an audit of all current grievances to ensure they are properly addressed, and any missing items are replaced when appropriate. Prevention: All grievances will be discussed with the management team during morning meeting upon receiving them and assigned to the proper manager. All grievances will be investigated including completing the appropriate grievance form, documenting findings and correspondences in point click care, and following up with any agreements and/or interventions. All missing items will be replaced within the agreed upon time frame where applicable. The grievance process will be completed within 72hrs apart from shipping for replaced items where applicable. The grievance binder	01/27/2025

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Based on record review and interview, the facility failed to ensure resident rights were implemented related to the investigation of missing items for 1 of 3 residents reviewed for misappropriation of property. (Resident G)

Finding includes:

Resident G's record was reviewed on 12/27/24 at 9:40 a.m. Diagnoses included, but were not limited to, unspecified dementia and angina. The resident resided on the locked memory care unit.

A Grievance Form was completed by the Director of Nursing (DON) on 10/23/24. The resident's daughter indicated hair care products were missing and requested the items be replaced. There was no follow up documented on the Grievance Form.

Progress Notes from 10/16/24 to 12/10/24 lacked any documentation regarding missing items.

During an interview with the Clinical Operations Specialist on 12/27/24 at 10:25 a.m., she indicated she had no knowledge of the grievance or if it was resolved. The DON who completed the Grievance Form was no longer employed at the facility.

will be monitored for completion and accuracy weekly by the DON indefinitely. The ED will sign off on all grievances upon completion. All grievances will be reviewed monthly during QA indefinitely. Responsible party: ED, DON or Designee

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During a telephone interviewed on 12/27/24 at 10:37 a.m., the resident's daughter indicated the hair care products were never replaced and there had been no follow up.

This citation relates to Complaint IN00448580.

Based on record review and interview, the facility failed to ensure resident rights were implemented related to the investigation of missing items for 1 of 3 residents reviewed for misappropriation of property. (Resident G)

Finding includes:

Resident G's record was reviewed on 12/27/24 at 9:40 a.m. Diagnoses included, but were not limited to, unspecified dementia and angina. The resident resided on the locked memory care unit.

A Grievance Form was completed by the Director of Nursing (DON) on 10/23/24. The resident's daughter indicated hair care products were missing and requested the items be replaced. There was no follow up documented on the Grievance Form.

Progress Notes from 10/16/24 to 12/10/24 lacked any documentation regarding missing items.

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	During an interview with the Clinical Operations Specialist on 12/27/24 at 10:25 a.m., she indicated she had no knowledge of the grievance or if it was resolved. The DON who completed the Grievance Form was no longer employed at the facility. During a telephone interviewed on 12/27/24 at 10:37 a.m., the resident's daughter indicated the hair care products were never replaced and there had been no follow up. This citation relates to Complaint IN00448580.			
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 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 accurately documented related	R 0349	What Has Been Done to Correct? The DON or designee will complete an investigation of all current grievances to ensure they are properly addressed, and documented in point click care. All missing items will be replaced when appropriate. How Will Recurrence Be Prevented? All grievances will be discussed with the management team during morning meeting upon receiving them and assigned to the proper manager. All grievances will be investigated including completing the appropriate grievance form, documenting findings and correspondences in point click care, and following up with any agreements and/or interventions. The grievance process will be completed in entirety within 72hrs if	01/27/2025

to the investigation of a grievance for 1 of 3 residents reviewed for misappropriation of property. (Resident F)

Finding includes:

The closed record for Resident F was reviewed on 12/26/24 at 2:30 p.m. Diagnoses included, but were not limited to dementia, anemia, seizures, and high blood pressure. The resident expired on 12/9/24.

A Quarterly Assessment, dated 12/3/24, indicated the resident had moderate cognitive impairment and required minimum staff assistance with activities of daily living.

A Grievance Form, dated 12/13/24, indicated the resident's rings were missing, and the daughter wanted them for the resident's burial. There was no documentation of a follow-up or resolution.

The resident's clinical record lacked documentation about the grievance.

During an interview on 12/26/24 at 11:00 a.m., the DON (Director of Nursing) indicated the resident's daughter was supposed to talk to other family members to see if they had the rings. If the rings were not located, the daughter was going to come search the resident's room. The DON indicated the

there are no items that require replacement. The grievance binder will be monitored for completion and accuracy weekly by the DON indefinitely. The ED will sign off on all grievances upon completion. All grievances will be reviewed monthly during QA indefinitely. Person Responsible:DON or Designee Due Date:1/27/25

resident's memorial had already passed and the daughter did not come search the room. She indicated the Grievance Form and resident's clinical record lacked documentation of an investigation or resolution of the grievance.

This citation is related to Complaint IN00448580.

Based on record review and interview, the facility failed to ensure clinical records were accurately documented related to the investigation of a grievance for 1 of 3 residents reviewed for misappropriation of property. (Resident F)

Finding includes:

The closed record for Resident F was reviewed on 12/26/24 at 2:30 p.m. Diagnoses included, but were not limited to dementia, anemia, seizures, and high blood pressure. The resident expired on 12/9/24.

A Quarterly Assessment, dated 12/3/24, indicated the resident had moderate cognitive impairment and required minimum staff assistance with activities of daily living.

A Grievance Form, dated 12/13/24, indicated the resident's rings were missing, and the daughter wanted them for the resident's burial. There was no documentation of a

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FORM APPROVED

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OMB NO. 0938-0391

follow-up or resolution.

The resident's clinical record lacked documentation about the grievance.

During an interview on 12/26/24 at 11:00 a.m., the DON (Director of Nursing) indicated the resident's daughter was supposed to talk to other family members to see if they had the rings. If the rings were not located, the daughter was going to come search the resident's room. The DON indicated the resident's memorial had already passed and the daughter did not come search the room. She indicated the Grievance Form and resident's clinical record lacked documentation of an investigation or resolution of the grievance.

This citation is related to Complaint IN00448580.

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