

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 09/04/2025	
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 Intake IN00464529. This visit was in conjunction with the Post Survey Revisit (PSR) to the Investigation of Intake IN00463654 completed on 7/31/2025. Intake IN00464529 - No deficiencies related to the allegations are cited. Intake IN00463654 - corrected Survey date: September 4, 2025 Facility number: 002627 Residential Census: 104 Brentwood At Hobart was found to be in compliance with 410 IAC 16.2-5 in regard to the Investigation of Intake IN00464529. Quality review completed on 9/8/25.	R 0000					

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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	