

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

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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS       |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:                                 |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING<br>B. WING |                      | (X3) DATE SURVEY COMPLETED<br><br>08/18/2026 |  |
| NAME OF PROVIDER OR SUPPLIER<br><br>BRENTWOOD AT HOBART |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | STREET ADDRESS, CITY, STATE, ZIP CODE<br><br>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                                                  | <p>INITIAL COMMENTS</p> <p>This visit was for the Investigation of Intakes 471158 and 471464.</p> <p>Intake 471158 - State deficiency related to the allegations is cited at R052.</p> <p>Intake 471464 - No deficiencies related to the allegations are cited.</p> <p>Survey dates: August 17 and 18, 2026</p> <p>Facility number: 002627</p> <p>Residential Census: 114</p> <p>This State Residential Finding is cited in accordance with 410 IAC (Indiana Administrative Code)16.2-5.</p> <p>Quality review completed on 8/21/26.</p> | R 0000                                                                             | <p>The submission of this plan of correction does not indicate an admission by Brentwood at Hobart Senior Living 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.</p> |                                                      |                      |                                              |  |
| R 0052                                                  | Residents' Rights - Offense                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | R 0052                                                                             | This facility will ensure residents                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                                                      | 09/01/2026           |                                              |  |

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| <p>410 IAC 16.2-5-1.2(v)(1-6)</p> <p>(v) Residents have the right to be free from:</p> <p>(1) sexual abuse;</p> <p>(2) physical abuse;</p> <p>(3) mental abuse;</p> <p>(4) corporal punishment;</p> <p>(5) neglect; and</p> <p>(6) involuntary seclusion.</p> <p>Based on observation, record review and interview, the facility failed to ensure residents were safe from potential abuse related to ineffective follow up monitoring for memory care residents who had reported sexual behavior allegations and had dementia for 2 of 3 residents reviewed for abuse. (Residents B and C)</p> <p>Finding includes:</p> <p>A Facility Reported Incident (FRI), dated 7/30/26, indicated CNA 1 had entered Resident B's room to put laundry away and resident C was lying on Resident B's bed with his pants down. Resident B was touching his genitals in a sexual way. Resident B was fully dressed. The residents were separated immediately, and both were assessed for injury, with no injuries noted. The residents</p> | <p>are free from potential abuse related to ineffective follow up monitoring for memory care residents who had reported sexual behavior allegations and had a dementia diagnosis. All residents in memory care have the potential to be affected by this deficient practice. The facility completed an audit of the memory care unit; no other residents were affected by this deficient practice. Monitoring orders were placed in ECP for both residents affected stating that staff will check their location in memory care every 2 hours. Memory care coordinator will audit checks twice weekly for 2 months, then weekly for 2 months, then monthly for 2 months. Results will be discussed in monthly QA meetings.</p> |
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OMB NO. 0938-0391

remained separated in common areas of the memory care unit and both residents were placed on increased safety checks and alert charting. Both residents' responsible parties were notified and educated that the residents still had sexual urges, regardless of age or diagnosis. The facility indicated they would try to prevent inappropriate behaviors by keeping the residents in separate areas.

The investigation included filing an incident report, daily huddle education for 72 hours regarding Residents B and C, and increased safety checks, which began on 7/29/26.

The safety checks were documented as follows:

7/29/26 - 2:00 p.m., 6:00 p.m., 9:00 p.m., and 11:00 p.m.

7/30/26 - 3:00 a.m., 8:00 a.m., 11:00 a.m., 2:00 p.m., 6:00 p.m., 9:00 p.m., and 11:00 p.m.

7/31/26 - 3:00 a.m., 8:00 a.m., 11:00 a.m., 2:00 p.m., 6:00 p.m., 9:00 p.m., and 11:00 p.m.

A written statement by CNA 1, dated 7/29/26, indicated she went to check on Resident B and found Resident C in the room lying on the bed with Resident B next to him. Resident B had her hand in Resident C's pants.

On 8/19/26 at 9:40 a.m., Resident B was going to be observed with the Administrator. The room door was locked and the Administrator used a key to open the door. Upon entering the room, Resident B was observed lying on her bed fully clothed and Resident C was sitting on the couch across from the bed also fully clothed. The two residents were talking calmly and quietly. The Administrator redirected Resident C and walked him out of the room. Resident B indicated that Resident C was her "real blood brother" and he was cooking for her. Resident B remained lying in bed, she was calm and cooperative.

a. The record for Resident B was reviewed on 8/17/26 at 10:19 a.m. Diagnoses included, but were not limited to, dementia, anxiety, and chronic kidney disease.

A Service Plan, dated 3/26/26, indicated the resident had severe impairment for daily decision making. The resident was independent with toileting,

and grooming. Walking and mobility required supervision and cueing.

A Nurse's Note, dated 7/29/26 at 4:35 p.m., indicated an incident report had been created for sexual behavior.

b. The record for Resident C was reviewed on 8/17/26 at 3:01 p.m. Diagnoses included, but were not limited to, dementia, anxiety, and psychotic disorder with delusions.

A Service Plan dated 6/9/26, indicated the resident required full assistance with incontinence, grooming, and toileting. The resident was independent with walking and mobility.

A Psychiatric Note dated 7/16/26 indicted the resident presented as confused and was unable to follow eye movement direction on a neurological assessment. The resident had anxiety symptoms: compulsions, irritable, and obsessive.

A Nurse's Note, dated 7/29/26 at 4:48 p.m., indicated an incident report had been created for sexual behavior.

During an interview on 8/17/26 at 9:52 a.m., the Memory Care (MC) Coordinator indicated Resident C must have just

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walked in and sat down because the door was propped open earlier. She could not recall a timeline of when Resident C went into Resident B's room because they did not have cameras. She had gone to put a fan in the activity area because it had felt a little warm, and that was at 9:15 a.m. Resident C was observed at the time standing by the activity cart. There was an aide on break and so there was only one other aide and an LPN on the floor who was completing medication pass. They do not have an activity director, so she directed activities and there were 31 residents on the unit. Resident B liked to keep her door open and often placed a trash can at the entrance to prop it open. Staff had to remove other residents from wandering in her room. The resident had a fear of the closed door and did not like being alone. When rounding, staff would ensure Resident B was in her room alone. When Resident B was awake, she would walk into the main living area or would walk the halls and was rarely in her room.

During an interview on 8/17/26 at 10:00 a.m., LPN 1 indicated she did not work in MC all the time but was aware that Resident B and C gravitated towards each other. Resident B

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believed that Resident C is her husband. She was unsure when she last saw Resident C in the activity area, but she knew it was "not long ago." She had been keeping an on where he was. Resident B was taken to her room to toilet by the CNA and that is how she ended up back in her room. The only way Resident C could have gotten in her room was if Resident B opened the door.

During an interview on 8/17/26 at 10:09 a.m., CNA 2 indicated she had opened the door for Resident B to use the restroom because her door was locked. Resident B was able toilet herself independently once in her room. CNA 2 indicated she left the room, closed the door and made sure it was locked. Resident B had to have opened the door back up for Resident C to come into her room. She could not recall a time, but insisted it "wasn't that long ago" and staff had been keeping them apart.

During an interview on 8/17/26 at 1:37 p.m., CNA 1 indicated she had previously walked into Resident B's room and had seen them both lying across the bed next to each other. Resident B had her hands in Resident C's pants above the brief. Resident C still had his brief on, and Resident B's hand

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was between the brief and the pants, it was not under the brief. Resident B became very upset and indicated that Resident C was her husband and did not want him to leave the room. CNA 1 had worked in the MC unit for over a year and that was the first time they were found in a room together. She indicated it was hard to keep them separated because "they are like magnets, they gravitate toward one another."

During an interview on 8/17/26 at 1:33 p.m., the MC Coordinator indicated staff did not do monitoring every fifteen minutes or every two hours because the residents were always in the main area. She understood the increased safety checks lacked consistency with monitoring.

This citation relates to Intake 471158.

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 Searfeair Sutherland

TITLEDON

(X6) DATE 09/01/2026