STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING B. WING	01/31/2025

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 IN00450703, IN00450736, IN00450862, & IN00451388. Complaint IN00450703 - State deficiencies related to the allegations are cited at R117 and R144. Complaint IN00450736 - State deficiency related to the allegations is cited at R117. Complaint IN00450862 - State deficiency related to the allegations is cited at R117. Complaint IN00451388 - State deficiency related to the allegations is cited at R117. Unrelated deficiencies are cited. Survey date: January 29, 30, and 31, 2025 Facility number: 002627 Residential Census: 106	R 0000	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. We respectfully request a desk review in this matter.	

	These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review completed on 2/6/25.			
R 0088	Administration and Management - Noncompliance 410 IAC 16.2-5-1.3(c)(1-2)(d)(1-2) c) The licensee shall: (1) appoint an administrator with either a: (A) comprehensive care facility administrator license as required by IC 25-19-1-5(c); or (B) residential care facility administrator license as required by IC 25-19-1-5(d); and (2) delegate to that administrator the authority to organize and implement the day-to-day operations of the facility. (d) The licensee shall notify the director: (1) within three (3) working days of a vacancy in the administrator's position; and (2) of the name and license number of the replacement administrator Based on record review and interview, the facility failed to notify the Indiana Department of Health (IDOH) of a new	R 0088	The facility is actively recruiting for a licensed residential care facility administrator. Once a qualified candidate is secured, the facility will complete the required state Form 55444 titled Administrator or Director of Nursing Change form. The Regional Director of Operations or designee will complete an audit within 48hrs of any administrator change to ensure compliance. The Regional Director of Operations or designee will monitor compliance by auditing and ensuring the state form titled Administrator or Director of Nursing Change form (State Form 55444) is completed and emailed to IDOH LTC Provider Services within 72 hours of any Administrator change.	02/24/2025

	replacement Administrator within three working days of administration vacancy. Finding includes: The previous Administrator last worked on 12/13/2024. The new Administrator was appointed on 12/14/2024. Notification of the new Administrator was submitted to IDOH on 1/30/25. During an interview on 1/30/25 at 11:02 a.m., the Regional Director indicated the Regional Clinical Director submitted the change in Administrator and understood the change should have been made within three working days. Based on record review and interview, the facility failed to notify the Indiana Department of Health (IDOH) of a new replacement Administrator within three working days of administration vacancy. Finding includes: The previous Administrator last worked on 12/13/2024. The new Administrator was appointed on 12/14/2024. Notification of the new Administrator was submitted to IDOH on 1/30/25. During an interview on 1/30/25			

	at 11:02 a.m., the Regional Director indicated the Regional Clinical Director submitted the change in Administrator and understood the change should have been made within three working days.			
R 0117	Personnel - Deficiency 410 IAC 16.2-5-1.4(b) (b) Staff shall be sufficient in number, qualifications, and training in accordance with applicable state laws and rules to meet the twenty-four (24) hour scheduled and unscheduled needs of the residents and services provided. The number, qualifications, and training of staff shall depend on skills required to provide for the specific needs of the residents. A minimum of one (1) awake staff person, with current CPR and first aid certificates, shall be on site at all times. If fifty (50) or more residents of the facility regularly receive residential nursing services or administration of medication, or both, at least one (1) nursing staff person shall be on site at all times. Residential facilities with over one hundred (100) residents regularly receiving residential nursing services or administration of medication, or both, shall have at least one (1) additional nursing staff person awake and on duty at all times for every additional fifty (50) residents. Personnel shall be assigned only those duties for which they are trained to perform. Employee duties shall conform with written job descriptions.	R 0117	An audit of all nursing staff certifications was completed. All staff without CPR/First aid certifications were obtained. Staffing schedules have been corrected and the daily schedules will reflect the correct number of staff with CPR/First aid certifications for each shift daily. The facility scheduler was educated on staffing the facility with adequate qualified staff members each shift daily. The daily schedule will identify staff members with the proper certifications by adding a C/FA next to all employees with CPR/First aid certifications each shift daily. The facility will staff the building appropriately with a minimum of 2 staff members with said certifications each shift daily. DON or designee will audit the daily schedule twice per week for 1 month, then weekly for 2 months, then monthly for 2 months to ensure the facility is staffed accordingly and remain in compliance.	02/24/2025

Based on record review and interview, the facility failed to ensure there was at least one staff member with a current first aid and CPR (cardiopulmonary resuscitation) certification scheduled for 3 of 21 shifts reviewed. This had the potential to affect all 106 residents residing in the facility.

Finding includes:

Employee CPR and First Aid certificates were reviewed on 1/31/25 at 10:56 a.m.

There was no one CPR/first aid certified in the building on the following shifts:

- 1/16/25 night shift

- 1/17/25 evening and night shift

During an interview on 1/31/25 at 11:39 a.m., the Director of Nursing (DON) indicated she understood the concern and had no further information to provide.

This State Residential tag relates to Complaints IN00450703, IN00450736, IN00450862, and IN00451388.

Based on record review and interview, the facility failed to ensure there was at least one staff member with a current first aid and CPR (cardiopulmonary

	resuscitation) certification scheduled for 3 of 21 shifts reviewed. This had the potential to affect all 106 residents residing in the facility. Finding includes: Employee CPR and First Aid certificates were reviewed on 1/31/25 at 10:56 a.m. There was no one CPR/first aid certified in the building on the following shifts: - 1/16/25 night shift - 1/17/25 evening and night shift During an interview on 1/31/25 at 11:39 a.m., the Director of Nursing (DON) indicated she understood the concern and had no further information to provide. This State Residential tag relates to Complaints IN00450703, IN00450736, IN00450862, and IN00451388.			
R 0144	Sanitation and Safety Standards - Deficiency 410 IAC 16.2-5-1.5(a) (a) The facility shall be clean, orderly, and in a state of good repair, both inside and out, and shall provide reasonable comfort for all residents.	R 0144	On 01/30/2025, all of the environmental concerns identified during the survey were immediately addressed. Food and debris on the floor were cleaned up. The spilled liquid was mopped and cleaned up. Food and garbage on the couch were removed. and the garbage in the bathroom was removed. The plunger in the bathroom was also replaced.	02/24/2025

	Based on observation and interview, the facility failed to maintain an environment that was clean and in good repair related to dirty floors, dirty furniture, and a dirty bathroom, for 1 of 2 units observed throughout the facility. (Memory Care Unit) Finding includes: During a random observation on the Memory Care Unit on 1/29/25 at 7:55 p.m. with QMA 1, the following was observed: In room 426 there was an accumulation of food and debris on the floor along with spilled liquid. There was food and garbage on the couch where the resident was sitting. There was a buildup of dried food and liquid on the resident's bedside table. The bathroom had garbage and other debris on the floor and there was a plunger in the corner next to the toilet that had soiled toilet paper beneath it. During an interview at the time, QMA 1 indicated he needed to get a broom and clean up the floor. During an interview on 1/31/25 at 8:31 a.m., the Director of Nursing (DON) indicated she understood the environmental concerns and had no additional information to provide.		An In-service was conducted with housekeeping staff on 01/30/2025 by the Maintenance Director regarding the environmental area sited by ISDH. The Memory Care Coordinator or designee will complete daily room checks to ensure compliance and report any adverse findings to the Executive Director, Maintenance Director, or DON during Morning meeting. The Maintenance Director will complete weekly spot checks to ensure compliance. Any findings, thereafter, will be immediately addressed and reported to the Executive Director. Any further issues will be addressed promptly and discussed with the QA committee.	

This State Residential tag relates to Complaint IN00450703.

Based on observation and interview, the facility failed to maintain an environment that was clean and in good repair related to dirty floors, dirty furniture, and a dirty bathroom, for 1 of 2 units observed throughout the facility. (Memory Care Unit)

Finding includes:

During a random observation on the Memory Care Unit on 1/29/25 at 7:55 p.m. with QMA 1, the following was observed:

In room 426 there was an accumulation of food and debris on the floor along with spilled liquid. There was food and garbage on the couch where the resident was sitting. There was a buildup of dried food and liquid on the resident's bedside table. The bathroom had garbage and other debris on the floor and there was a plunger in the corner next to the toilet that had soiled toilet paper beneath it.

During an interview at the time, QMA 1 indicated he needed to get a broom and clean up the floor.

During an interview on 1/31/25 at 8:31 a.m., the Director of Nursing (DON) indicated she

	understood the environmental concerns and had no additional information to provide. This State Residential tag relates to Complaint IN00450703.			
R 0306	Pharmaceutical Services - Noncompliance 410 IAC 16.2-5-6(g)(1-9) (g) Medications administered by the facility shall be disposed in compliance with appropriate federal, state, and local laws, and disposition of any released, returned, or destroyed medication shall be documented in the resident ' s clinical record and shall include the following information: (1) The name of the resident. (2) The name and strength of the drug. (3) The prescription number. (4) The reason for disposal. (5) The amount disposed of. (6) The method of disposition. (7) The date of the disposal. (8) The signature of the person conducting the disposal of the drug. (9) The signature of a witness, if any, to the disposal of the drug.	R 0306	The employee in question was immediately provided documented education/Inservice on the proper disposal of narcotic medications. An Inservice was conducted with all nursing staff on the proper procedure for the disposal of narcotic medications including obtaining signatures of two qualified nursing staff members prior to the disposal of narcotic medications on the narcotic count log. DON or designee will audit the narcotic log sheets twice weekly for 4 weeks, then weekly for 4 weeks, then monthly indefinitely to ensure compliance. Any additional interventions will be discussed with the QA committee.	02/24/2025

Based on observation, record review, and interview, the facility failed to documented a wasted narcotic and have a second witness verify waste for 1 of 5 residents reviewed during medication pass observation. (Memory Care Medication Cart)

Finding includes:

On 1/29/25 at 9:23 p.m., medication pass was observed with QMA 1. Resident N received 1 tablet of Ativan (anxiety medication). QMA 1 went to document in the narcotic book and signed out Ativan with 12 tablets left. The Ativan medication card had 11 remaining Ativan tablets.

During an interview at the time, QMA 1 indicated he had accidentally crushed the previous Ativan tablet when he was popping the tablet out of the medication card. QMA 1 indicted he wasted the medication in the sharps container and did not have a witness verify the waste.

During an interview on 1/29/25 at 9:34 p.m., the Administrator and Director of Nursing indicated they would investigate the medication error immediately.

Based on observation, record review, and interview, the facility failed to documented a wasted narcotic and have a second

witness verify waste for 1 of 5 residents reviewed during medication pass observation. (Memory Care Medication Cart)

Finding includes:

On 1/29/25 at 9:23 p.m., medication pass was observed with QMA 1. Resident N received 1 tablet of Ativan (anxiety medication). QMA 1 went to document in the narcotic book and signed out Ativan with 12 tablets left. The Ativan medication card had 11 remaining Ativan tablets.

During an interview at the time, QMA 1 indicated he had accidentally crushed the previous Ativan tablet when he was popping the tablet out of the medication card. QMA 1 indicted he wasted the medication in the sharps container and did not have a witness verify the waste.

During an interview on 1/29/25 at 9:34 p.m., the Administrator and Director of Nursing indicated they would investigate the medication error immediately.

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