

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 07/30/2024
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 a Post Survey Revisit (PSR) to Investigation of Complaint IN00434733 completed on May 22, 2024. Complaint IN00434733 - Corrected Survey dates: July 30, 2024 Facility number: 002627 Residential Census: 119 Brentwood at Hobart was found to be in compliance with 410 IAC 16.2-5 in regard to the PSR to Investigation of Complaint IN00434733. Quality review completed on 7/31/24. This visit was for a Post Survey Revisit (PSR) to Investigation of Complaint IN00434733 completed on May 22, 2024. Complaint IN00434733 - Corrected	R 0000		

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FORM APPROVED

OMB NO. 0938-0391

Survey dates: July 30, 2024 Facility number: 002627 Residential Census: 119 Brentwood at Hobart was found to be in compliance with 410 IAC 16.2-5 in regard to the PSR to Investigation of Complaint IN00434733. Quality review completed on 7/31/24.				
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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
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