STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING B. WING	07/31/2025

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 Complaint IN00463654. Complaint IN00463654 - State deficiencies related to the allegations are cited at R052, R090 and R096. Survey date: 7/31/25 Facility number: 002627 Residential Census: 106 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review completed on 8/5/25.	R 0000	The submission of this plan of correction does not indicate an admission by Brentwood at Hobart 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. Brentwood at Hobart respectfully request from the department a desk review/paper compliance for these tags.¿	
R 0052	Residents' Rights - Offense 410 IAC 16.2-5-1.2(v)(1-6) (v) Residents have the right to be free from: (1) sexual abuse;	R 0052	It is the policy of this community that all residents will be free from all forms of abuse. No other residents were affected by this deficient practice. No prolonged adverse effects were noted for the resident involved	08/22/2025

	(2) physical abuse; (3) mental abuse; (4) corporal punishment; (5) neglect; and (6) involuntary seclusion. Based on record review and interview, the facility failed to protect a resident's right to be free from abuse related to a resident residing on the Memory Care Unit being physically abused by an agency QMA while witnessed by two facility CNAs who did not intervene. This resulted in the resident sustaining scratches to her right arm, bruising to her right upper arm, reddening to the back of her left shoulder, bruising to her right knee and a hospital evaluation. (Resident B) Findings include: Resident B's record was reviewed on 7/31/25 at 10:15 a.m. Diagnoses included, but were not limited to, mild dementia with mood disturbance, anxiety and chronic pain. She resided on the locked Memory Care Unit. The Initial Level of Care Assessment, dated 5/30/25, indicated the resident was alert to person, place and time, and was independent with mobility,		in this deficient practice. All staff were trained in abuse policy and reporting. All agency staff will have abuse policy and reporting training prior to their first shift. DON or will verify and maintain all training. DON or will audit all agency staff training records twice weekly for 2 months, then weekly for 1 month then as needed if agency staffing is still being used.	

	toileting and hygiene. She needed stand-by assistance for bathing and daily medication management. A Behavior Note, dated 6/16/25, indicated, "At 11pm resident was seen pacing up and down the hallway yelling and using profanity. At 11:15 p.m. Qma was waiting for the elevator. While waiting on the elevator, a cna stood nearby making sure resident wouldn't try to get on the elevator. The resident attacked the qma. Resident scratched the qma face and pulled her wig off of her head. The qma tried to restrain the resident and eased her to the ground. Once resident was on the ground she continued to fight and use profanity towards staff. Resident was redirected several times. (DON) was notified of incident..." An Incident Note, dated 6/17/25 at 4:49 p.m., indicated after the investigation of behavior report and skin assessment had been completed, the resident had scratches to the right arm, bruising to the right upper arm, a reddened area to the back of the left shoulder and right knee bruising. There were no complaints of pain.			

	A Communication Note, dated 6/17/25 at 6:33 p.m., indicated the daughter was notified of the incident. A Communication Note, dated 6/17/25 at 6:47 p.m., indicated a police report had been made. An IDOH (Indiana Department of Health) Facility Reported Incident (FRI), dated 6/17/25, indicated on 6/16/25, Agency QMA 1 (qualified medication aide) had been physically aggressive with Resident B on the Memory Care Unit. The FRI indicated, "...Staff QMA reported that an agency QMA was 'physically aggressive' with a resident on the memory care post-fall...." and, "...Full body assessment completed: R arm scratches, R upper arm bruising, back of L shoulder redden [sic] area and R knee bruising...." The follow up, dated 6/24/25, indicated, "...Employee interviews in the surrounding area were conducted and a trend was identified as the agency QMA making contact with the resident...QMA banned from employment from community and licence [sic] investigated...." A witness statement by CNA 1, dated 6/18/25, indicated on 6/16/25 at approximately 11:00 p.m., QMA 1 was observed walking toward the elevator.			

	Resident B began walking quickly behind her toward the elevator. "...and before the QMA could enter the code, [Resident B] scratched her face and pulled off her wig...the QMA reacted by pushing [Resident B] against the wall and holding her arms down...." CNA 1 and CNA 2 began walking towards them to intervene. CNA 2 verbally told the resident that she cannot attack staff like that. The resident broke free from the QMA and another physical struggle occurred. They fell into a resident's room still fighting. CNA 1 indicated she could not see what was happening as CNA 2 was in the doorway between them, but she could hear the struggle and the resident saying, "your'e [sic] breaking my arm", and "your'e [sic] choking me". CNA 2 continued to tell the resident she had to quit hurting the staff. CNA 1 indicated she did not intervene at anytime during the incident. They eventually let the resident up and she went back to her room using her walker. CNA 1 resigned on 6/19/25. A Communication Note, dated 6/18/25 at 10:00 a.m., indicated the daughter was notified of sending the resident to the hospital for an evaluation to make sure she had no injuries. A Health Status Note, dated 6/18/25 at 6:47 p.m., indicated			

	the resident had returned from the hospital after being evaluated with no new injuries or orders. During an interview on 7/31/25 at 9:42 a.m., Resident B indicated she remembered the incident. She didn't recognize the QMA so she asked her name. The QMA wouldn't answer, so she tapped her and pulled on her hair a little and her wig came off. "She threw me in a room and tackled me, banged my head and strangled me". Resident B indicated she had gone to the hospital for a neck X-ray and had a sprained neck and some bruising. During an interview on 7/31/25 at 12:49 p.m., the Administrator in Training (AIT) indicated she had not been notified of the incident until 2:30 p.m. the following day. After she watched the surveillance video, she contacted the police and sent the resident to the hospital to be evaluated. The AIT indicated when interviewed, CNA 2 was very quiet and did not say much, she had been terminated at that time. Witness statements from CNA 2 and QMA 1 were requested and not available. The undated document, titled, "Elder Abuse Policy and Procedure", indicated, "Each			

	resident has the right to be free from abuse, corporal punishment, mistreatment, and involuntary seclusion. Residents must not be subjected to abuse by anyone including, but not limited to: facility staff, other residents, consultants or volunteers, staff of other agencies serving the resident, family member or legal guardian, friends or other individuals..." and, "Training: Employees are trained through orientation and on-going sessions on issues related to abuse prohibition practices such as: Appropriate interventions to deal with aggressive and/or catastrophic reactions of residents..." This citation relates to Complaint IN00463654. Based on record review and interview, the facility failed to protect a resident's right to be free from abuse related to a resident residing on the Memory Care Unit being physically abused by an agency QMA while witnessed by two facility CNAs who did not intervene. This resulted in the resident sustaining scratches to her right arm, bruising to her right upper arm, reddening to the back of her left shoulder, bruising to her right knee and a hospital evaluation. (Resident B)			

	Findings include: Resident B's record was reviewed on 7/31/25 at 10:15 a.m. Diagnoses included, but were not limited to, mild dementia with mood disturbance, anxiety and chronic pain. She resided on the locked Memory Care Unit. The Initial Level of Care Assessment, dated 5/30/25, indicated the resident was alert to person, place and time, and was independent with mobility, toileting and hygiene. She needed stand-by assistance for bathing and daily medication management. A Behavior Note, dated 6/16/25, indicated, "At 11pm resident was seen pacing up and down the hallway yelling and using profanity. At 11:15 p.m. Qma was waiting for the elevator. While waiting on the elevator, a cna stood nearby making sure resident wouldn't try to get on the elevator. The resident attacked the qma. Resident scratched the qma face and pulled her wig off of her head. The qma tried to restrain the resident and eased her to the ground. Once resident was on the ground she continued to fight and use profanity towards staff. Resident was redirected several times. (DON) was notified of incident..."			

	An Incident Note, dated 6/17/25 at 4:49 p.m., indicated after the investigation of behavior report and skin assessment had been completed, the resident had scratches to the right arm, bruising to the right upper arm, a reddened area to the back of the left shoulder and right knee bruising. There were no complaints of pain. A Communication Note, dated 6/17/25 at 6:33 p.m., indicated the daughter was notified of the incident. A Communication Note, dated 6/17/25 at 6:47 p.m., indicated a police report had been made. An IDOH (Indiana Department of Health) Facility Reported Incident (FRI), dated 6/17/25, indicated on 6/16/25, Agency QMA 1 (qualified medication aide) had been physically aggressive with Resident B on the Memory Care Unit. The FRI indicated, "...Staff QMA reported that an agency QMA was 'physically aggressive' with a resident on the memory care post-fall...." and, "...Full body assessment completed: R arm scratches, R upper arm bruising, back of L shoulder redden [sic] area and R knee bruising...." The follow up, dated 6/24/25, indicated, "...Employee interviews in the surrounding area were conducted and a			

	trend was identified as the agency QMA making contact with the resident...QMA banned from employment from community and licence [sic] investigated...." A witness statement by CNA 1, dated 6/18/25, indicated on 6/16/25 at approximately 11:00 p.m., QMA 1 was observed walking toward the elevator. Resident B began walking quickly behind her toward the elevator. "...and before the QMA could enter the code, [Resident B] scratched her face and pulled off her wig...the QMA reacted by pushing [Resident B] against the wall and holding her arms down...." CNA 1 and CNA 2 began walking towards them to intervene. CNA 2 verbally told the resident that she cannot attack staff like that. The resident broke free from the QMA and another physical struggle occurred. They fell into a resident's room still fighting. CNA 1 indicated she could not see what was happening as CNA 2 was in the doorway between them, but she could hear the struggle and the resident saying, "your'e [sic] breaking my arm", and "your'e [sic] choking me". CNA 2 continued to tell the resident she had to quit hurting the staff. CNA 1 indicated she did not intervene at anytime during the incident. They eventually let the resident up and she went back			

	to her room using her walker. CNA 1 resigned on 6/19/25. A Communication Note, dated 6/18/25 at 10:00 a.m., indicated the daughter was notified of sending the resident to the hospital for an evaluation to make sure she had no injuries. A Health Status Note, dated 6/18/25 at 6:47 p.m., indicated the resident had returned from the hospital after being evaluated with no new injuries or orders. During an interview on 7/31/25 at 9:42 a.m., Resident B indicated she remembered the incident. She didn't recognize the QMA so she asked her name. The QMA wouldn't answer, so she tapped her and pulled on her hair a little and her wig came off. "She threw me in a room and tackled me, banged my head and strangled me". Resident B indicated she had gone to the hospital for a neck X-ray and had a sprained neck and some bruising. During an interview on 7/31/25 at 12:49 p.m., the Administrator in Training (AIT) indicated she had not been notified of the incident until 2:30 p.m. the following day. After she watched the surveillance video, she contacted the police and sent the resident to the hospital to be evaluated. The AIT indicated			

	when interviewed, CNA 2 was very quiet and did not say much, she had been terminated at that time. Witness statements from CNA 2 and QMA 1 were requested and not available. The undated document, titled, "Elder Abuse Policy and Procedure", indicated, "Each resident has the right to be free from abuse, corporal punishment, mistreatment, and involuntary seclusion. Residents must not be subjected to abuse by anyone including, but not limited to: facility staff, other residents, consultants or volunteers, staff of other agencies serving the resident, family member or legal guardian, friends or other individuals..." and, "Training: Employees are trained through orientation and on-going sessions on issues related to abuse prohibition practices such as: Appropriate interventions to deal with aggressive and/or catastrophic reactions of residents..." This citation relates to Complaint IN00463654.			
R 0090	Administration and Management - Deficiency 410 IAC 16.2-5-1.3(g)(1-6) (g) The administrator is responsible	R 0090	It is the policy of this community to complete and submit a follow up report in a timely manner for all IDOH reported incidents. All facility reported incidents from the past 60	08/22/2025

	for the overall management of the facility. The responsibilities of the administrator shall include, but are not limited to, the following: (1) Informing the division within twenty-four (24) hours of becoming aware of an unusual occurrence that directly threatens the welfare, safety, or health of a resident. Notice of unusual occurrence may be made by telephone, followed by a written report, or by a written report only that is faxed or sent by electronic mail to the division within the twenty-four (24) hour time period. Unusual occurrences include, but are not limited to: (A) epidemic outbreaks; (B)poisonings; (C) fires; or (D) major accidents. If the division cannot be reached, a call shall be made to the emergency telephone number published by the division. (2) Promptly arranging for or assisting with the provision of medical, dental, podiatry, or nursing care or other health care services as requested by the resident or resident's legal representative. (3) Obtaining director approval prior to the admission of an individual under eighteen (18) years of age to an adult facility. (4) Ensuring the facility maintains, on the premises, an accurate record of actual time worked that		days were reviewed; any late submissions were identified and corrected. The ED or designee will maintain an incident tracking log documenting the date of the initial report submission, required follow up due date, and actual follow-up submission date to monitor timeliness and ensure ongoing compliance with IDOH reporting requirements. The ED or will verify each follow-up submission prior to the deadline. The ED or will perform weekly audits of the Tracking log for 3 months to maintain ongoing regulatory compliance. Findings from the audits will be reviewed during monthly QA meetings.	

	indicates the: (A) employee's full name; and (B) dates and hours worked during the past twelve (12) months. (5) Posting the results of the most recent annual survey of the facility conducted by state surveyors, any plan of correction in effect with respect to the facility, and any subsequent surveys. The results must be available for examination in the facility in a place readily accessible to residents and a notice posted of their availability. (6) Maintaining reports of surveys conducted by the division in each facility for a period of two (2) years and making the reports available for inspection to any member of the public upon request Based on record review and interview, the facility failed to submit a follow-up report timely for an IDOH (Indiana Department of Health) Facility Reported Incident (FRI), for 1 of 2 residents reviewed for incidents. (Resident C) Finding includes: Resident C's record was reviewed on 7/31/25 at 2:00 p.m. Diagnoses included, but were not limited to, dementia, psychotic disturbance and anxiety delusional disorders. A Quarterly Level of Care Assessment, dated 7/14/25,			

indicated the resident was alert to person and place and required supervision, reminders and cues every two hours by nursing.

A FRI dated 7/21/25, indicated the resident was observed with a reddish-purple discoloration, measuring 5 centimeters (cm) x 5 cm, above her right knee of unknown origin.

The FRI indicated the resident was assessed for pain, the Physician and Power of Attorney were notified and she was placed on increased monitoring. A root cause investigation was initiated.

The follow up on the FRI was blank.

During an interview on 7/31/25 at 3:15 p.m., the Director of Nursing indicated the follow up report had not been completed or submitted. She had not been aware the follow up was not submitted.

During an interview on 7/31/25 at 4:15 p.m., the Administrator in Training indicated follow up reports should be submitted within 72-hours.

This citation relates to Complaint IN00463654.

Based on record review and interview, the facility failed to submit a follow-up report timely

for an IDOH (Indiana Department of Health) Facility Reported Incident (FRI), for 1 of 2 residents reviewed for incidents. (Resident C)

Finding includes:

Resident C's record was reviewed on 7/31/25 at 2:00 p.m. Diagnoses included, but were not limited to, dementia, psychotic disturbance and anxiety delusional disorders.

A Quarterly Level of Care Assessment, dated 7/14/25, indicated the resident was alert to person and place and required supervision, reminders and cues every two hours by nursing.

A FRI dated 7/21/25, indicated the resident was observed with a reddish-purple discoloration, measuring 5 centimeters (cm) x 5 cm, above her right knee of unknown origin.

The FRI indicated the resident was assessed for pain, the Physician and Power of Attorney were notified and she was placed on increased monitoring. A root cause investigation was initiated.

The follow up on the FRI was blank.

During an interview on 7/31/25 at 3:15 p.m., the Director of Nursing indicated the follow up

	report had not been completed or submitted. She had not been aware the follow up was not submitted. During an interview on 7/31/25 at 4:15 p.m., the Administrator in Training indicated follow up reports should be submitted within 72-hours. This citation relates to Complaint IN00463654.			
R 0096	Administration and Management - Deficiency 410 IAC 16.2-5-1.3(m)(1-2)(A-B)(i-iii) (m) The director of the Alzheimer's and dementia special care unit shall do the following: (1) Oversee the operation of the unit. (2) Ensure that: (A) personnel assigned to the unit receive required in-service training; and (B) care provided to Alzheimer's and dementia care unit residents is consistent with: (i) in-service training; (ii) current Alzheimer's and dementia care practices; and (iii) regulatory standards. Based on record review and	R 0096	It is the policy of this community that all staff have dementia training. All Agency staff members will be provided an orientation and in servicing on the following policies: orientation to the community, disaster preparedness, reporting abuse and neglect, the phone number of the ED, DON, ADON for reporting emergencies and or reporting abuse, Dementia Training.¿¿ The orientation will be completed by our nursing scheduler and/or Designee, and a copy of the signed orientation and training will be kept by the nursing scheduler/ and or designee. The DON or will audit these documents twice weekly for 2 months, then weekly for 1 month, then as needed if agency staff is still being utilized. ¿¿¿¿¿¿¿¿¿¿¿¿¿	08/22/2025

interview, the facility failed to ensure agency staff had received dementia training and orientation prior to working on the Memory Care Unit for 1 of 2 incidents reviewed. (QMA 1 and Resident B)

Finding includes:

Resident B's record was reviewed on 7/31/25 at 10:15 a.m. Diagnoses included, but were not limited to, dementia mild with mood disturbance, anxiety and chronic pain.

The Initial Level of Care Assessment, dated 5/30/25, indicated the resident was alert to person, place and time, and was independent of mobility, toileting and hygiene. She needed stand by assistance for bathing and daily medication management.

An IDOH (Indiana Department of Health) Facility Reported Incident (FRI), dated 6/17/25, indicated on 6/16/25 Agency QMA 1 (qualified medication aide) had been physically aggressive with Resident B on the memory care unit.

The FRI indicated, "...Staff QMA reported that an agency QMA was 'physically aggressive' with a resident on the memory care post-fall...." and, "...Full body assessment completed: R [right] arm scratches, R upper arm bruising, back of L [left] shoulder

redden [sic] area and R knee bruising...." The follow up, dated 6/24/25, indicated, "...Employee interviews in the surrounding area were conducted and a trend was identified as the agency QMA making contact with the resident...QMA banned from employment from community and licence investigated...."

During an interview on 7/31/25 at 9:58 a.m., the Memory Care Coordinator indicted she had been in her position since 6/30/25. She did not do any training or orientation with agency staff, she was not sure who did that or when.

During an interview on 7/31/25 at 10:02 a.m., the Director of Nursing (DON) indicated she was not the DON when the incident with Resident B occurred. The DON, scheduler and corporate staff did the approval of agency staff and to her knowledge, there was no type of orientation. The facility did not do background checks, they relied on the staffing agency to have that completed but she was unaware of any protocol to check. They did not keep employee files for agency staff. The DON indicated there was no policy available related to agency staff.

On 7/31/25 at 4:45 p.m., the DON was able to access QMA

1's trainings and background check through the staffing agency website. The QMA did not have dementia training.

The undated document, "Elder Abuse Policy and Procedure", indicated, "...All new employees will receive Elder Abuse/ Resident Rights training in new employee orientation and annually thereafter....", and, "...Training: Employees are trained through orientation and on-going sessions on issues related to abuse prohibition practices such as: Appropriate interventions to deal with aggressive and/or catastrophic reactions of residents..."

This citation relates to Complaint IN00463654.

Based on record review and interview, the facility failed to ensure agency staff had received dementia training and orientation prior to working on the Memory Care Unit for 1 of 2 incidents reviewed. (QMA 1 and Resident B)

Finding includes:

Resident B's record was reviewed on 7/31/25 at 10:15 a.m. Diagnoses included, but were not limited to, dementia mild with mood disturbance, anxiety and chronic pain.

The Initial Level of Care Assessment, dated 5/30/25,

indicated the resident was alert to person, place and time, and was independent of mobility, toileting and hygiene. She needed stand by assistance for bathing and daily medication management.

An IDOH (Indiana Department of Health) Facility Reported Incident (FRI), dated 6/17/25, indicated on 6/16/25 Agency QMA 1 (qualified medication aide) had been physically aggressive with Resident B on the memory care unit.

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agency staff, she was not sure who did that or when.

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On 7/31/25 at 4:45 p.m., the DON was able to access QMA 1's trainings and background check through the staffing agency website. The QMA did not have dementia training.

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	aggressive and/or catastrophic reactions of residents..." This citation relates to Complaint IN00463654.			

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