STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING B. WING	09/04/2025

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 Post Survey Revisit (PSR) to the Investigation of Intake IN00463654 completed on 7/31/2025. This visit was in conjunction with the the Investigation of Intake IN00464529. Intake IN00463654 - Corrected Intake IN00464529 - No deficiencies related to the allegations are cited. 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 PSR to the Investigation of Intake IN00463654. 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