STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING B. WING	04/08/2026

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 a Post Survey Revisit (PSR) to the Investigation of Intakes 465370, 465908, 466055, 466132, 466139, 466620, 466646, 467186, and 467340 completed on 2/4/26. Intake 465370 - State deficiencies related to the allegations are cited at R0240. Intake 465908 - Corrected. Intake 466055 - Corrected. Intake 466132 - Corrected. Intake 466139 - State deficiencies related to the allegations are cited at R0240. Intake 466620 - State deficiencies related to the allegations are cited at R0240. Intake 466646 - State deficiencies related to the allegations are cited at R0240.	R 0000	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.	

	Intake 467186 - State deficiencies related to the allegations are cited at R0240. Intake 467340 - State deficiencies related to the allegations are cited at R0217 and R0240. Survey dates: March 7 and 8, 2026 Facility number: 002627 Residential Census: 106 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review completed on 4/15/26.			

R 0036	Residents' Rights- Deficiency 410 IAC 16.2-5-1.2(k)(1-2) (k) The facility must immediately consult the resident ' s physician and the resident ' s legal representative when the facility has noticed: (1) a significant decline in the resident ' s physical, mental, or psychosocial status; or (2) a need to alter treatment significantly, that is, a need to discontinue an existing form of treatment due to adverse consequences or to commence a new form of treatment.	R 0036	This facility will ensure clinical recordsare complete and accurately documented, including notifying the MD of any changes in conditions. All residents have the potential to be affected by this deficient practice. No adverse effects were noted for any other residents. The DON/Designee will audit all chartingusing an audit form. Audits will be completed twice per week for 2 months, then weekly for 2 months, then monthly for 2 months. All results will be reviewed during our monthly QA meeting.	04/30/2026
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; (2) physical abuse; (3) mental abuse; (4) corporal punishment; (5) neglect; and (6) involuntary seclusion.	R 0052	This facility will ensure residents are free from abuse.All residents have the potential to be affected by this deficient practice. No adverse effects were noted for any other residents.All staff were educated on the abuse policy. Any suspected abuse will be reported to the Stateboardof Health. All employees involved will be immediatelysuspended pending investigationandappropriate disciplinaryactionup to and including termination will apply according to the results of investigation. All staff will complete Relias abuse training upon hire and annually. The ED/Designee will audit all abuse training to ensure compliance monthly for 6 months using the audit tool. All results will be reviewed during our monthly QA meeting.	04/30/2026

R 0086	Administration and Management - Deficiency 410 IAC 16.2-5-1.3(a)(1-2) The licensee: (1) is responsible for compliance with all applicable laws; and (2) has full authority and responsibility for the: (A) organization; (B) management; (C) operation; and (D) control; of the licensed facility. The delegation of any authority by the licensee does not diminish the responsibilities of the licensee.	R 0086	R 086. Administration and Management. It is the procedure and intent of the corporation to supervise and schedule any maintenance issue that may arise in terms of building services. The state inspector tagged out the working elevators and requested upgraded service to the elevators. The community followed the directive of the state inspector who tagged out the elevators, but also allowed us to use other working elevators, located on opposite sides of the community until the requested upgrades were completed. What Corrective actions will be accomplished for those residents found to be have been affected by the deficient practices: The elevators that were placed under lock out/tag out of service by the inspector have been upgraded per code. We have worked with several vendors working to satisfy the requirements of the state for several months. The community has provided oversight and supervision since the tag out and continue to do so. Other elevators in the community are functioning and have been available for use by residents, staff and families. We understand it may be inconvenient for some of the	04/30/2026

			residents, but it is not a deficient practice to have 2 working elevators. How the facility will identify other residents having the potential to be affected by the same deficient practice: All residents have the potential to be affected. All residents may use the other two working elevators while the tagged-out elevators are cleared to begin operation again. What measures will be put into place or what systemic changes will the facility make to ensure that the deficient practice does not recur. The community is committed to resolving and satisfying the upgraded work requested by the State inspector. We have been working with our vendors since this time and coordinated their services for each to complete a specific task, which has been completed. Our Elevator Vendor has requested the state inspector to come out several times to inspect the elevators. How the corrective actions will be monitored to ensure the deficient practice will not recur. The community remains responsive and will continue to work with our vendors (Elevator vendor, Fire panel vendors, and other vendors) needed to perform this requested work. All	

			requested work by vendors have been completed the elevator vendor has reached out to the State of Indiana inspector to come inspect the elevators. Our elevator vendor has submitted the request again for the State of Indiana inspector for a date and time of the inspection. By what date the systematic changes will be completed. The community's elevator vendor has requested the state inspector to make a onsite inspection and allow us to use the elevators again. The date of the inspection is completely up to the state inspector to schedule a date and time with the community. We will let the residents, family, and staff know once the State inspector allows us to operate the tagged-out elevators. As of now, the State of Indiana inspector is scheduled to come out by the end of February 2026.	
R 0116	Personnel - Noncompliance 410 IAC 16.2-5-1.4(a) (a) Each facility shall have specific procedures written and implemented for the screening of prospective employees. Appropriate inquiries shall be made for prospective employees. The facility shall have a personnel policy that considers references	R 0116	This facility will ensure that all staff are properly screened prior to working in the building. An audit of all employee files was completed. All staff who were noted without reference checks completed were identified. Reference checks have been completed for all employees noted. This facility will not allow staff to work until all on-boarding including referencechecksare completed. The ED/Designee will	04/30/2026

	and any convictions in accordance with IC 16-28-13-3.		auditall newemployee files prior to their start date to ensure on-boardingiscompletedincluding reference checks. All findings will be reviewed during our monthly QA meeting.	
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	This facility willmaintainaclean and safe environment. All residents have the potential to be affected by this deficient practice.The building was audited by the management team for compliance. All problem areas wereidentified. Cleaning schedules weremodified, and housekeeping staff were made aware of the changes.House keepingmanagerwill audit compliance twice weekly for 2 months, then weekly for 2 months, then monthly for 2 months.All findings will be reviewed during our monthly QA meeting.	04/30/2026
R 0177	Physical Plant Standards - Deficiency 410 IAC 16.2-5-1.6(a) (a) The facility shall make provisions for the handicapped as required by state or federal codes.	R 0177	Physical and Plant standards. It is the policy of Brentwood of Hobart to monitor and make repairs to building equipment such as doors and devices such as handicap accessible open door assist whether completed inhouse or contracted out services. What Corrective actions will be accomplished for those residents found to be have been affected by the deficient practices: All residents had the potential to be affected. How the facility will identify other	04/30/2026

			residents having the potential to be affected by the same deficient practice: All doors will be inspected by maintenance department for proper function specifically focused on handicap accessible buttons functioning properly. What measures will be put into place or what systemic changes will the facility make to ensure that the deficient practice does not recur. The maintenance department has secured two quotes for an outside vendor to repair the handicap accessible button. Once this work has been completed, the wiring will allow the restoration of the magnetic locks. How the corrective actions will be monitored to ensure the deficient practice will not recur. The maintenance director and or designee will check all exterior doors twice a week for 4 weeks then weekly thereafter. By what date the systematic changes will be completed. Community has received two quotes from vendors to perform this work. One vendor will be selected to perform the work by 2/21/26 and we will ask the vendor to complete the repair and install within 30 days. The community would like to ask for an extension to have the contracted work completed by	

			March 22 2026.	
R 0216	Evaluation - Noncompliance 410 IAC 16.2-5-2(c)(1-4)(d) (c) The scope and content of the evaluation shall be delineated in the facility policy manual, but at a minimum the needs assessment shall include an evaluation of the following: (1) The resident ' s physical, cognitive, and mental status. (2) The resident ' s independence in the activities of daily living. (3) The resident ' s weight taken on admission and semiannually thereafter. (4) If applicable, the resident ' s ability to self-administer medications. (d) The evaluation shall be documented in writing and kept in the facility.	R 0216	This facility will ensure only residents who are able to self-administer havemedications in their possession. All residents have the potential to be affected by this deficient practice.Staff members who were negligent in this practice were given disciplinary action.An audit was completed for all residents todetermine appropriateness for self-administration. All nursing staff were educated on proper medication administration and self-administrationpolicies. DON/Designee will complete monthly self-administration assessments for appropriate residentsindefinitely. All findings will be reviewed during our monthly QA meeting.	04/30/2026
R 0217	Evaluation - Deficiency 410 IAC 16.2-5-2(e)(1-5) (e) Following completion of an evaluation, the facility, using appropriately trained staff members, shall identify and document the services to be provided by the facility, as follows: (1) The services offered to the	R 0217	This facility will ensure that we follow service plans as written. All residents have the potential to be affected by this deficient practice. All service plans were¿reviewed,¿and residents requiring cuesor encouragement to eatand residents requiring assistance with bathing were¿identified.Orders were placed in ECP for care givers to	04/30/2026

	individual resident shall be appropriate to the: (A) scope; (B) frequency; (C) need; and (D) preference; of the resident. (2) The services offered shall be reviewed and revised as appropriate and discussed by the resident and facility as needs or desires change. Either the facility or the resident may request a service plan review. (3) The agreed upon service plan shall be signed and dated by the resident, and a copy of the service plan shall be given to the resident upon request. (4) No identification and documentation of services provided is needed if evaluations subsequent to the initial evaluation indicate no need for a change in services. (5) If administration of medications or the provision of residential nursing services, or both, is needed, a licensed nurse shall be involved in identification and documentation of the services to be provided. Based on record review and interview, the facility failed to ensure service plans were in place and implemented related		document showers, meal consumption, andrefusals for each shift.Staff who did not have access to ECP have been given access tochart.Family members and MD will be notified of refusals with proper documentation in the resident electronic records. DON/Designee will audit records to ensure compliance twice weekly for 2 months, then weekly for 2 months, then monthly for 2 months. All findings will be reviewed during our monthly QA meeting.¿	

	to bathing and eating assistance for 2 of 3 residents reviewed for activities of daily living (ADL) care. (Residents M and R) Findings include: 1. The record for Resident M was reviewed on 4/8/26 at 9:00 a.m. Diagnoses included, but were not limited to, neuromuscular dysfunctions of the bladder. During an interview on 4/8/26 at 11:00 a.m., Resident M indicated she had lived at the facility for approximately a year. She indicated she thought she would be getting shower assistance, but had only received three showers by staff. There was no service plan related to ADL care. The Care Provided History was blank. There was no documentation of any ADL assistance, included bathing, since 3/2/26. The facility had changed their electronic record systems effective 3/2/26. The previous electronic record indicated the resident had an ADL Service Plan, dated 4/8/25, and required assistance for bathing twice weekly on Monday and Friday. 2. The record for Resident R was reviewed on 4/8/26 at			

	10:25 a.m. Diagnoses included, but were not limited to, dementia. The resident resided on the locked memory care unit. A list of residents that required prompting or cueing to eat was provided by the Administrator. Resident R was on the list. A Service Plan, dated 3/3/26, indicated the resident was independent with eating, requires no assistance with eating meals. May prepare own meals. The Care Provided History was did not include any documentation related cueing or prompting the resident to eat. During an interview on 4/8/26 at 1:30 p.m., the Administrator was made aware of the missing and incorrect service plans and lack of documentation for ADL care. She had no additional information. This deficiency was cited on 2/4/26. The facility failed to implement a systemic plan of correction to prevent recurrence.			
R 0240	Health Services - Deficiency 410 IAC 16.2-5-4(d) (d) Personal care, and assistance with activities of daily living, shall	R 0240	This facility will ensure that ADL care is provided as scheduled. All residents have the potential to be affected by this deficient practice. No other residents	04/30/2026

	be provided based upon individual needs and preferences. 3. The record for Resident B was reviewed on 4/8/26 at 9:52 a.m. Diagnoses included, but were not limited to, anemia and atrial fibrillation A Quarterly Assessment, dated 12/10/25, indicated the resident required assistance with incontinence management 6 times a day. The Care Provided history, dated 3/3/26-4/8/26, lacked documentation of any incontinence care was provided. During an interview on 4/8/26 at 1:07 p.m., the Administrator was unable to provide any documentation of incontinence care. She indicated the staff should be documenting the incontinence care in the computer system under the care provided. This deficiency was cited on 2/4/26. The facility failed to implement a systemic plan of correction to prevent recurrence. Based on record review and interview, the facility failed to ensure residents received the assistance needed with activities of daily living (ADL) related to bathing and		were identified as being affected.All service plans were reviewed,and residentsrequiring incontinencecare wereidentified. Orders were placed in ECP for staff to chart whenincontinence care is providedor refusedeach shift.Staff who were unable to chart previously have been given access tochartin ECP. Failure to provide scheduled ADL care will result in disciplinary action. The DON/Designee will audit all ADL charting to ensure compliance. Audits will be completed¿twice weekly for 2 months, then weekly for 2 months, then monthly for 2 months. All findings will be reviewed during our monthly QA meeting.¿	

	incontinence care for 3 of 3 residents reviewed. (Residents G, M and B) Findings include: 1. The record for Resident G was reviewed on 4/7/26 at 11:30 a.m. Diagnoses included, but were not limited to, dementia. A Service Plan, dated 3/2/26, indicated the resident required prompting and reminding with bathing. The Care Provided History indicated she was scheduled for bath or shower on Monday and Thursday during the day shift. There were refusals documented 4/2/26 and 4/6/26, on 3/2/26 the resident was documented as not available. There were no completed baths or showers documented since 3/2/26. During an interview on 4/8/26 at 1:30 p.m., the Administrator indicated the resident would frequently refuse showers, but her daughter would come in and was able to shower her. She indicated this should be documented. 2. The record for Resident M was reviewed on 4/8/26 at 9:00 a.m. Diagnoses included, but were not limited to, neuromuscular dysfunctions of			

	the bladder. During an interview on 4/8/26 at 11:00 a.m., Resident M indicated she had lived at the facility for approximately a year. She indicated she thought she would be getting shower assistance, but had only received three showers by staff. There was no updated service plan related to ADL care. The Care Provided History was blank. There was no documentation of any ADL assistance, included bathing, since 3/2/26. The facility had changed their electronic record systems effective 3/2/26. The previous electronic record indicated the resident had an ADL Service Plan, dated 4/8/25, and required assistance for bathing twice weekly on Monday and Friday. During an interview on 4/8/26 at 1:30 p.m., the Administrator was made aware of the missing service plan and lack of documentation. She had no additional information.			
R 0349	Clinical Records - Noncompliance 410 IAC 16.2-5-8.1(a)(1-4) (a) The facility must maintain clinical records on each resident.	R 0349	This facility will complete follow up documentation post falls, change in condition, andmonitoringorders with vitals. An audit of all records for the past90 dayshas been completed. No other residents	04/30/2026

	These records must be maintained under the supervision of an employee of the facility designated with that responsibility. The records must be as follows: (1) Complete. (2) Accurately documented. (3) Readily accessible. (4) Systematically organized.		were identified as being affected by this deficient practice.Nursing staff were educated on proper documentation for all changes in conditions.The DON/Designee will audit records for compliancetwice weekly for 2 months, then weekly for 2 months, then monthly for 2 months. All findings will be reviewed during our monthly QA meeting.	

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 SIGNATURESearfeeair Sutherland	TITLEDON	(X6) DATE04/22/2026