STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
		A. BUILDING 00 B. WING	06/02/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
BRENTWOOD AT HOBART	1420 ST MARYS CIRCLE HOBART, IN 46342

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
R 0000 Bldg. 00	This visit was for the Investigation of Complaints IN00457244, IN00458361, IN00458602, IN00458769, IN00458913, IN00458959, IN00459301, IN00459996, and IN00460168. Complaint IN00457244 - State deficiencies related to the allegations are cited at R0241. Complaint IN00458361 - State deficiencies related to the allegations are cited at R0144, R0214, R0217, R0240, and R0241. Complaint IN00458602 - State deficiencies related to the allegations are cited at R0045, R0090, R0116, R0119, R0120, and R0240. Complaint IN00458769 - State deficiencies related to the allegations are cited at R0214, R0217, R0240, R0349. Complaint IN00458913 - State deficiencies related to the allegations are cited at R0144, R0214, R0217, R0240, and R0349. Complaint IN00458959 - State deficiencies related to the allegations are cited at R0045, R0090, R0116, R0119, R0120, R0240, R0349, R0354. Complaint IN00459301 - No deficiencies related to the allegations are cited. Complaint IN00459996 - State deficiencies related to the allegations are cited at R0036, R0214, R0217, R0240, R0349. Complaint IN00460168 - No deficiencies related to the allegations are cited.	R 0000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Susan Wiley	RDCS	07/01/2025

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determin other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclo days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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	Survey dates: May 27, 28, 29, 30, and June 2, 2025 Facility number: 002627 Residential Census: 98 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review completed on 6/9/25.			
R 0036 Bldg. 00	410 IAC 16.2-5-1.2(k)(1-2) Residents' Rights- Deficiency Based on record review and interview, the facility failed to ensure residents' family/Responsible Party were notified of falls, change of status, and new physician's orders for 2 of 3 residents reviewed for family notification. (Residents C and M) Findings include: 1. Resident C's record was reviewed on 5/28/25 at 3:15 p.m. The diagnoses included, but were not limited to, dementia, stroke, history of falls, and legal blindness. A QMA Progress Note, dated 5/8/25 at 11:40 p.m., indicated the resident was found sitting on the floor in front of the recliner. The Director of Nursing (DON) was notified. The resident was assisted off the floor and to the recliner with no complaints of pain. There was no documentation the resident's family/Responsible Party had been notified.	R 0036	=”” p=””> =”” p=”” considered. <=”” p All residents have the potential to be affected. An audit was completed by the Director of Nursing (DON) or designee with no other residents identified as being affected. All nursing staff were educated on residents’ rights and requirement of notification of family/Responsible Party for falls, change in condition, and new/change physician orders. The DON or designee will review the twenty-four-hour report and physicians' orders five times per week for 12 weeks to ensure all family/Responsible parties were notified. Results of the audits will be reviewed in the monthly Quality Assurance (QA) meeting. The Executive Director/designee is responsible for sustained compliance.	06/20/2025

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	2. During an interview on 5/29/25 at 8:20 a.m., the Resident M's Responsible Party indicated the resident had laboratory tests ordered and she had not been made aware of the testing or the reason. She had received a text there were new test results in his "My Chart" and that is how she was aware the tests had been completed. Resident M's record was reviewed on 5/30/25 at 10:14 a.m. The diagnoses included, but were not limited to, dementia. A Nurse Practitioner's Order, written on 5/14/25, indicated laboratory tests of complete blood count, comprehensive metabolic panel, and a urinalysis with culture and sensitivity if indicated due to an altered mental status and increased urgency. There was no documentation in the record that indicated the Responsible Party had been notified of the change in status and the new orders. During an interview on 5/30/25 at 10:50 a.m., QMA 6 indicated the Responsible Party should have been notified. During an interview with Executive Director (ED) 4 and the Administrator in Training (AIT) on 5/30/25 at 12:40 p.m., ED 4 indicated there was no facility policy for physician/family notification and the facility followed the State regulations. During an interview on 6/2/25 at 9:05 a.m., DON 1 and DON 2 indicated there was no further information on the above findings. This citation relates to IN00459996.			

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R 0045 Bldg. 00	410 IAC 16.2-5-1.2(r)(6-9) Residents' Rights - Deficiency Based on record review and interview, the facility failed to ensure the Local Long Term Care Ombudsman received a copy of an involuntary discharge notice for 1 of 1 resident who received an involuntary discharge notice. (Resident B) Finding includes: Resident B was interviewed on 5/27/25 at 4:38 p.m. and indicated the Administrator In Training (AIT) had given her a 30 day discharge notice on 4/23/25. Resident B appealed the discharge and contacted the Ombudsman herself. A Discharge Notice, dated 4/23/25, indicated the notice was given and sign by the AIT, Resident B, and Director of Nursing (DON) 2. The notice indicated the resident was given the Ombudsman contact information. The packet did not indicate the local Ombudsman had been notified of the 30 day involuntary discharge notice by the facility. An email from the Deputy Director Ombudsman, dated 5/28/25 at 3:12 p.m., indicated there had been no copy of the involuntary discharge notice sent to the local or State Ombudsman's office. During an interview on 6/2/25 at 9:56 a.m., Executive Director (ED) 5 indicated he had been conversing by email with the Deputy Director Ombudsman. The facility had a copy of the certified mailed notice to the resident but not the certified mail to the Ombudsman. This citation relates to Complaints IN00458602 and IN00458959.	R 0045	=”” p=””> Resident B continues to reside in the community and was assessed and noted to be free of negative affects. All residents have the potential to be affected. An audit was conducted on Facility Initiated Discharges, no further residents’ were identified as being affected. The Regional Director of Operations (RDO)/designee educated the Executive Director (ED) and DON on the requirements to notify the Local Long Term Care Ombudsman regarding facility initiated discharges and the requirement to provide a signed copy of the notice. The ED will conduct a weekly audit times twelve weeks to ensure the facility meets all the reporting/notification requirements for all facility-initiated discharges. Results of the audits will be reviewed in the monthly QA meeting. The Executive Director/designee is responsible for sustained compliance.	06/20/2025

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R 0090 Bldg. 00	410 IAC 16.2-5-1.3(g)(1-6) Administration and Management - Deficiency Based on record review and interview, the facility failed to ensure an allegation of abuse was reported to the Indiana Department of Health (IDOH) and failed to ensure a second allegation of abuse was reported timely to the IDOH for 1 of 2 residents reviewed for abuse. (Resident B) Finding includes: During an interview on 5/27/25 at 4:38 p.m., Resident B indicated she had been admitted into the hospital on 4/30/25 with bronchial pneumonia and when she returned to the facility (5/3/25), she left her room to go to the dining room and was told by Director of Nursing (DON) 1 she had to stay in her room. DON 1 then pushed her in the middle of her chest and told her she needed to go back to her room. Resident B indicated she had notified the local police and they arrived at the facility and submitted a police report, which she had not yet picked up. During an interview on 5/28/25 at 8:35 a.m., DON 1 indicated when Resident B returned from the hospital, she was placed in isolation for 10 days due to respiratory symptoms or she would need to wear a mask if she left the room. She indicated the resident had made an allegation that DON 1 had "beat her up", and she notified the police. DON 1 indicated she had never touched the resident. DON 1 reported the allegation to the Administrator in Training (AIT). DON 1 indicated IDOH had not been notified since the alleged event had not occurred. During an interview on 5/28/25 at 8:55 a.m., the AIT indicated the allegation occurred on a	R 0090	=”” p=””> Resident B continues to reside in the community and was assessed and noted to be free of negative affects. All residents’ have the potential to be affected. An audit was completed by reviewing the facility twenty four hour report, no other residents’ were identified as being affected. The RDO/designee provided education to the ED and DON regarding the requirement to investigate and report any allegation of abuse to IDOH within twenty four hours. The ED/designee will review the twenty four hour report fives times per week times twelve weeks to ensure all potential allegations of abuse are investigated and reported timely. A log will be kept with written documentation of reporting. The results of the audits and logs will be reviewed at the facility monthly QA meetings. The Executive Director/designee is responsible for sustained compliance.	06/20/2025

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	Saturday and since it was late, she did not come in to talk to the resident until Sunday. The AIT had not reported the allegation to IDOH because she wanted to talk to the resident before she reported the allegation. The resident reported DON 1 had pushed her and threatened her. The AIT informed the resident she did not think that happened and the resident was upset and started screaming at her. The AIT indicated she did not have written statements from the resident, other residents, nor the staff who were interviewed. She had failed to do an investigation and report the allegation. During an interview on 5/28/25 at 12:45 p.m., Resident B indicated she had won an appeal for the 30 day notice she had received and an employee informed her "she better watch what she eats at the facility and be careful." She indicated this happened about 11:00 a.m. this morning and now she was scared to eat anything at the facility. Executive Director (ED) 4, the AIT, and DON 1 were notified of the allegation on 5/28/25 at 1:01 p.m. During an interview on 5/30/25 at 12:40 p.m., ED 4 indicated the allegation from 5/28/25 had not been reported to IDOH yet and she would notify IDOH of the allegation that day. Resident B's record was reviewed on 5/28/25 at 2:26 p.m. The diagnoses included, but were not limited to lupus and anxiety. A New Admission Level of Care assessment, dated 2/17/25 at 1:16 p.m., indicated the resident required no assistance with care, managed her own health, and was oriented to person, place, and time.			

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	An undated elder abuse policy, received from DON 1 on 5/27/25 at 7:00 p.m. as current, indicated the IDOH would be notified of all allegations of abuse within 24 hours and all allegations were to be investigated thoroughly. This citation relates to Complaints IN00458602 and IN00458959.			
R 0116 Bldg. 00	410 IAC 16.2-5-1.4(a) Personnel - Noncompliance Based on record review and interview, the facility failed to properly screen employees hired in the past four months, related to criminal background checks not completed with the Indiana State Police Repository or equivalent state agency for 5 of 5 employees hired in the past 4 months (Terminated CNA 10, Dietary Aide (DA) 13, QMA 14, CNA 15, and CNA 8) and also failed to obtain reference checks for DON 1 (Director of Nursing). Findings include: The Employee Files were reviewed on 5/28/25 at 7:00 a.m. 1. Terminated CNA 10's start date was 2/24/25. DA 13's start date was 2/18/25. QMA 14's start date was 3/10/25. CNA 15's start date was 3/10/25. CNA 8's start date was 5/14/25. The criminal background checks had not been completed with the Indiana State Police Repository or equivalent state agency. During an interview on 5/29/25 at 3:28 p.m., the Administrative Assistant indicated the criminal	R 0116	An audit was completed to ensure all current employee files are up-to-date including background checks and references. The RDO/designee provided education to the ED, DON, and Administrative Assistant (AA) on the requirement to ensure all pre-hire documents are submitted prior to a new employee starting in the community. The ED/Designee will conduct a weekly audit to ensure all new employee files include background check results and reference checks prior to start date. Results of the audit will be reviewed at the facility monthly QA meeting. The Executive Director/designee is responsible for sustained compliance. ="" p="">	06/20/2025

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	background checks had not been completed through the Indiana State Police Repository or equivalent state agency. 2. DON 1's start date was 3/17/25. The reference checks had not been completed. During an interview on 5/29/25 at 3:51 p.m., Executive Director (ED) 4 indicated the reference checks had not been completed for DON 1. An undated elder abuse policy, received from DON 1 on 5/27/25 at 7:00 p.m. as current, indicated reference checks and background checks would be completed prior to hiring. This citation relates to Complaints IN00458602 and IN00458959.			
R 0119 Bldg. 00	410 IAC 16.2-5-1.4(d)(1)(A-E)(2)(A-D)(3-Personnel - Noncompliance Based on record review and interview, the facility failed to ensure employees hired in the past four months received abuse education, resident rights education, and orientation upon being hired by the facility for 3 of 6 employees hired in the past four months. (Dietary Aide (DA) 13, QMA 14, and Terminated CNA 10) Finding includes: The Employee Files were reviewed on 5/28/25 at 7:00 a.m. Terminated CNA 10's start date was 2/24/25. DA 13's start date was 2/18/25. QMA 14's start date was 3/10/25.	R 0119	An audit was completed to ensure all current employee files are up-to-date including documentation of abuse education, residents rights education, and department/job specific orientation. The RDO/designee provided education to the ED, DON, and Administrative Assistant (AA) on the requirement to ensure all new employees receive education regarding Abuse and Residents Rights and have a signed job orientation prior to working independently in the community. The ED/Designee will conduct a	06/20/2025

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	DA 13 had not received abuse education, QMA 14 had not received resident rights education, and Terminated CNA 10 had no documentation that indicated orientation to the facility and policies had been completed. During an interview on 6/2/25 at 9:35 a.m., Executive Director (ED) indicated Terminated CNA 10's orientation had not been completed. An undated elder abuse policy, received from DON 1 on 5/27/25 at 7:00 p.m. as current, indicated all new employees would have education on elder abuse and resident rights. This citation relates to Complaints IN00458602 and IN00458959.		weekly audit to ensure all new employee files include abuse and resident rights education along with documented orientation. Results of the audit will be reviewed at the facility monthly QA meeting. The Executive Director/designee is responsible for sustained compliance. ="" p="">	
R 0120 Bldg. 00	410 IAC 16.2-5-1.4(e)(1-3) Personnel - Noncompliance Based on record review and interview, the facility failed to ensure employee inservice education was completed yearly related to abuse, resident rights, and dementia education for 5 of 5 employees who had worked at the facility longer than four months. (Dietary Aide (DA) 16, CNA 11, Housekeeper (HSK) 17, RN 3, and the Administrative Assistant) Finding includes: The Employee Files were reviewed on 5/28/25 at 7:00 a.m. DA 16's hire date was 11/6/23. There was only 0.5 hours of dementia training completed in 2024 or 2025. CNA 11's hire date was 8/10/23. There was no	R 0120	An audit was completed to ensure all current employee files are up-to-date and include annual education on abuse, resident rights, and dementia. The RDO/designee provided education to the ED, DON, and Administrative Assistant (AA) on the requirement to ensure employees receive the required number of education/in-services yearly. The ED/Designee will conduct a monthly audit to ensure all those employees with anniversary dates are up-to-date with education requirements for abuse, resident rights, and dementia. Results of the audit will be reviewed at the	06/20/2025

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	abuse, resident rights or dementia training completed in 2024 or 2025. HSK 17's hire date was 7/5/23. There was no abuse or resident rights training completed in 2024 or 2025. RN 3's hire date was 9/1/21. There was no abuse, resident rights, or dementia training completed in 2024 or 2025 The Administrative Assistant's hire date was 9/1/21. There was no abuse, resident rights, or dementia training completed in 2024 or 2025. During an interview on 5/29/25 at 3:51 p.m., Executive Director (ED) 4 indicated the training had not been completed. This citation relates to Complaints IN00458602 and IN00458959.		facility monthly QA meeting. The Executive Director/designee is responsible for sustained compliance. ="" p="">	
R 0144 Bldg. 00	410 IAC 16.2-5-1.5(a) Sanitation and Safety Standards - Deficiency Based on observation and interview, the facility failed to maintain an environment that was clean and in good repair related to dirt and debris on the floors, walls and windows, missing floor boards, gouges and scuffs on the walls, a broken window lock, broken bathroom fans, broken shower heads, a wobbly table, and a dirty over the bed table throughout all areas of the building. Findings include: 1. The following was observed on 5/27/25: a. At 4:38 p.m., the shower head in 301 bathroom	R 0144	="" p=""> Items identified as deficiencies have been corrected. All residents have the potential to be affected. The RDO provided education to the Maintenance Director and environmental services staff regarding the requirement to maintain an environment that is clean, orderly, and in a state of good repair, both inside and out, and shall provide reasonable comfort for all residents. All staff were educated regarding work orders and alerting environmental	06/20/2025

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	was broken and taped to the shower to secure. b. At 6:46 p.m., room 426 had trash, food, and debris on the floor, under the bed, and on the recliner. The over the bed table was dirty. 2. The following was observed on 5/28/25: a. At 11:13 a.m., there were several cracked and missing floor boards located in the hallway outside the east public bathroom on the first floor. b. At 11:15 a.m., the bedroom window in room 123 had a broken lock on the window. c. At 11:28 a.m., there was a broken floor board on the east elevator. d. At 11:51 a.m., room 409 had multiple scuffs on the wall by the bed and in the room entry way. The bathroom fan had a loud audible squeal and there were cobwebs on the vent. e. At 11:55 a.m., the Memory Care Unit hallway outside of room 412 had 7 areas where nails/hooks were sticking out of the wall and not covered with pictures. Next to the hallway door, there was a spot on the wall where an item was previously hanging and removed and the wall had not been repainted, and there were holes in the wall under the picture located by the outside door. f. At 11:57 a.m. The two columns outside the dining room and the corner by the dining room had missing drywall and cracks. There were holes in the wall by the fire extinguisher. g. At 12:23 p.m., the table in the back of the dining room on Memory Care was loose and		staff when cleaning/repairs are needed. The ED/Maintenance Director/Designee will conduct weekly walking rounds times 12 weeks to identify areas that need repaired both inside and out of the facility. The Maintenance Director will keep a monthly log of repairs monthly. The ED will review the logs during the facility monthly QA meeting. The Executive Director/designee is responsible for sustained compliance.	

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	wobbly. In the resident lounge behind the dining room, there was a piece of dried food on the heating unit, dirt and debris in the corners, missing and scuffed drywall, and remnents of a sticky backing of a picture on the wall behind the couch. 3. The following was observed on 5/29/25: a. At 8:20 a.m., room 412's shower head was unable to be secured and the fan in the bathroom light was not functional. b. At 8:25 a.m., the corner wall outside of room 223 had splintered trim and gouges out of the drywall. c. At 12:10 p.m., the bar over the end hallway window by room 406 was dirty with a brown substance on the rail and the screen was broken and bowed out. There was a large amount of debris on the window tracks. 4. The following was observed on 5/30/25: a. At 8 a.m., there was a water spot on the ceiling outside of room 116. b. At 8:10 a.m., there was no paint touch up on the walls outside of rooms 401, 403, 410, 412, 414, 433, and 424 after items were removed from the wall. The entry to the Memory Care Lounge had gouges out of the wall and corners of the entry. The hallway window, outside of room 429 had a large amount of debris and dirt on the ledge of the window. c. At 8:15 a.m., the food on the heating element and floor remain in the Memory Care Lounge			

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	behind the dining room. During a tour on 5/30/25 from 11:28 a.m. through 12:00 p.m. with the Vice President of Operations, she indicated the lounges were to be cleaned daily. She acknowledged all the above concerns. This citation relates to Complaints IN00458361 and IN00458913.			
R 0214 Bldg. 00	410 IAC 16.2-5-2(a) Evaluation - Deficiency Based on observation, record review and interview, the facility failed to ensure an updated evaluation of individual needs was completed with a change in resident status for 1 of 10 residents reviewed for evaluations. (Residents G) Finding includes: Resident G was identified by Director of Nursing (DON) 1 as requiring extensive to total assistance with activities of daily living (ADL's) on 5/27/25 at 7:00 p.m. During an observation on 5/28/25 at 11:19 a.m., CNA 12 indicated the resident required assistance to get to the dining room for meals. CNA 12 asked the resident if she needed to use the bathroom then assisted her into the bathroom. Resident G's record was reviewed on 5/29/25 at 1:40 p.m. The diagnoses included, but were not limited to, stroke. A Quarterly Level of Care assessment, dated 3/23/25, indicated prompting and reminding was required for bathing. She was independent for grooming, toileting and mobility, required minimal	R 0214	A Level of Care assessment was completed for resident G by a licensed nurse. All residents have the potential to be affected. An audit was completed for all current residents; no other residents were identified as being affected. Education was provided to the ED and DON regarding the requirement for updating resident evaluations as needs change, there is a significant change in status, or at minimum semiannually. The ED/Designee will audit monthly those residents identified as having a change in status/condition to ensure a new level of care assessment was completed time 3 months. The DON/designee will complete a monthly audit to identify those residents who have not have a level of care assessment completed within six months to ensure a new/updated level of care	06/20/2025

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	assistance with dressing and transfers. During an interview on 5/29/25 at 2:43 p.m., DON 1 indicated the resident was more dependent currently and a change of condition re-evaluation had not been completed. This citation relates to Complaints IN00458361, IN00458769, IN00458913, and IN00459996.		is completed. Results of the audits will be reviewed at the facility monthly QA meeting. The Executive Director/designee is responsible for sustained compliance. ="" p="">	
R 0217 Bldg. 00	410 IAC 16.2-5-2(e)(1-5) Evaluation - Deficiency Based on record review and interview, the facility failed to ensure service plans were correct and updated with changes in condition for 2 of 11 residents reviewed for service plans. (Residents C and G) Findings include: 1. During an observation on 5/28/25 at 12:02 p.m., Dietary Aide (DA) 7 delivered the meal tray to the room. He informed the resident what was served for the lunch meal and then left the room. DA 7 had not explained where the food was located on the plate. The resident asked what was on the plate and where the food was located. She was able to locate a chicken leg and then began to feed herself the meal. She drank a small Styrofoam cup of apple juice and wanted more juice to drink. During an interview on 5/28/25 at 12:09 p.m., QMA 6 indicated Resident C enjoyed drinking apple juice and should receive large plastic glasses of fluid with her meal, not the small Styrofoam glasses. Resident C was legally blind and required staff to assist her with meals and a CNA should have taken the meal tray to the resident and assisted her as needed.	R 0217	Resident C and Resident G service plans have been updated with the most recent level of care assessments. All residents have the potential to be affected. An audit was conducted on all current residents; no further residents were identified as being affected. The RDO provided education the ED and DON regarding the requirement to update services plan as resident needs change in accordance with the most recent level of care assessment. All nursing staff were educated on care refusals by the DON. The ED/designee will conduct a monthly audit times 3 months to ensure those residents who were identified as having a significant change, have updated services plans according to their level of care assessment. Results of the audits will be reviewed at the facility monthly QA meeting. The Executive Director/designee is	06/20/2025

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	Resident C's record was reviewed on 5/28/25 at 3:15 p.m. The diagnoses included, but were not limited to, dementia, stroke, history of falls, and legal blindness. A Service Plan, dated 10/8/24, indicated the resident was independent with eating and drinking. The interventions included she preferred to eat in her room and changes in eating and drinking were to be reported to the nurse. The Nurses' Progress Notes, dated 3/26/25 at 1:11 p.m. and 5/8/25 at 11:40 p.m. indicated the resident had fallen. A Fall Risk Assessment, dated 4/1/25, indicated a high risk for falls. A Quarterly Level of Care assessment, dated 4/3/25 at 5:59 p.m., indicated moderate assistance was required for bathing twice a week by a caregiver, moderate assistance was required for all activities of daily living (ADL's), the staff were to set up items, cue and use hands on assistance. Assistance was required for sight-related needs, and required verbal redirection. The Nurses' Progress Notes, dated 4/4/25 at 10:58 p.m. and 5/18/25 at 10:10 a.m., indicated the resident refused showers and care. The Nurse's Progress Note, dated 5/18/25 at 5:42 p.m., indicated she refused showers often. The Service Plan for eating and drinking had not included set up help was required due to blindness and larger cups of fluids were preferred. The were no Service Plans for falls/fall risk and		responsible for sustained compliance. ="" p="">	

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	refusal of care/showers. During an interview on 5/29/25 at 2:43 p.m., Director of Nursing (DON) 1 provided no further information in regards to the Service Plan. 2. Resident G was identified by Director of Nursing (DON) 1 as requiring extensive to total assistance with activities of daily living (ADL's) on 5/27/25 at 7:00 p.m. During an observation on 5/28/25 at 11:19 a.m., CNA 12 indicated the resident required assistance to get to the dining room for meals. CNA 12 asked the resident if she needed to use the bathroom then assisted her into the bathroom. Resident G's record was reviewed on 5/29/25 at 1:40 p.m. The diagnoses included, but were not limited to, stroke. A Service Plan, dated 6/19/24, indicated minimal assistance was required for dressing and undressing and required occasional assistance for transfers. A Service Plan, dated 6/19/24, indicated hospice services were being utilized for end of life care. There were no physician's orders or documentation that indicated the resident was receiving end of life hospice care. During an interview on 5/29/25 at 2:43 p.m., DON 1 indicated the resident was now more dependent on care and she was not receiving hospice end of life care. This citation relates to Complaints IN00458361,			

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	IN00458769, IN00458913, and IN00459996. 410 IAC 16.2-5-4(d) Health Services - Deficiency			
R 0240 Bldg. 00	Based on observation, record review, and interview, the facility failed to ensure residents who had fallen were assessed after the fall by a licensed nurse and follow up assessments were completed post fall, failed to ensure residents received assistance with meals and showers, failed to ensure a resident was monitored for further risk of elopement, failed to ensure interventions for resistive behaviors were utilized for a resident who resisted care, and failed to ensure a resident with a change of status that required intervention was assessed for 3 of 3 residents reviewed for falls, 3 of 4 residents reviewed for activities of daily living (ADL's), 1 of 1 resident reviewed for elopement, 1 of 3 residents reviewed for behaviors, and 1 of 1 resident reviewed for change of condition. (Residents C, D, E, F, H and M) Findings include: 1. Resident C's record was reviewed on 5/28/25 at 3:15 p.m. The diagnoses included, but were not limited to, dementia, stroke, history of falls, and legal blindness. A Service Plan, dated 9/19/24, indicated assistance was required and provided for bathing. A Service Plan, dated 9/19/24, indicated the resident had impaired visual function and was legally blind. The frequently used items were to easily accessible. A Service Plan, dated 2/13/24, indicated the	R 0240	All residents identified have updated service plans. All residents have the potential to be affected. An audit was conducted and no further residents were identified. The ED and DON were educated on the requirements for post pall assessments, ensuring residents receive assistance with meals and showers, elopement risk monitoring, behavior interventions for resistive care, and ensuring residents are assessed when noted to have a change in status Any resident identified as having a fall will be assessed by a license nurse/DON/ADON. The DON/designee will ensure all new fall interventions are documented/updated in the resident service plan. The DON/Designee will ensure residents who require assistance with meals and showers are provided assistance in accordance with their most recent level of care assessment. The DON/Designee will ensure those residents identified as at risk for elopement receive on-going monitoring and updated elopement risk assessments are completed. The DON/Designee will ensure all	06/20/2025

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	resident was independent for food and fluid consumption and she preferred to have her meals in the apartment. A fall assessment, dated 4/1/25, indicated a high risk for falls. A Quarterly Level of Care assessment, dated 4/3/25 at 5:59 p.m., indicated moderate assistance was required for bathing twice a week by a caregiver, moderate assistance was required for all activities of daily living (ADL's), the staff were to set up items, cue and use hands on assistance. Assistance was required for sight-related needs, and required verbal redirection. a. During an observation on 5/28/25 at 12:02 p.m., Dietary Aide (DA) 7 delivered the meal tray to the room. He informed the resident what was served for the lunch meal and then left the room. DA 7 had not explained where the food was located on the plate. The resident asked what was on the plate and where the food was located. She was able to locate a chicken leg and then began to feed herself the meal. She drank a small Styrofoam cup of apple juice and wanted more juice to drink. During an interview on 5/28/25 at 12:09 p.m., QMA 6 indicated Resident C enjoyed drinking apple juice and should have received large plastic glasses of fluid with her meal, not the small Styrofoam glasses. The resident was legally blind and required staff to assist her with meals and a CNA should have taken the meal tray to the resident and assisted her as needed. During an observation on 5/28/25 at 12:17 p.m., QMA 6 delivered two larger glasses of apple juice to the resident. The resident had laid back down in bed and stopped eating. QMA 6 assisted the		residents identified as having a change in status are assessed by a licensed nurse. The ED/DON/Designee will review all incidents including falls, elopements, exit seeking monthly to ensure all residents were assessed by a licensed nurse and interventions were implemented on the service plan. The ED/DON/Designee will review those residents identified as having a change in status have been assessed. Results will be reviewed at the facility monthly QA meeting. The Executive Director/designee is responsible for sustained compliance. ="" p="">	

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	resident to the side of the bed, explained where the food was located on the plate, and the resident began to feed herself. During an interview with the Memory Care Director on 5/28/25 at 1:35 p.m., she indicated the Dietary Aides have delivered the room trays for the past three years. She was unsure why the Dietary Aides deliver and set up the meals instead of the nursing staff. b. A QMA incident note, dated 3/26/25 at 1:11 p.m., indicated Resident C was found sitting on the floor at the foot of the bed and had been incontinent of urine. She indicated she had fallen from the bed and could not get up. The nurse was notified. The resident was then assisted to a standing position and assisted to the bathroom and a shower was given. The Power of Attorney was notified. There was no documented assessment of the resident after the fall by a Licensed Nurse. There were three Progress Notes after the fall, on 3/27/25 at 7:35 p.m., 3/29/25 at 6:09 p.m., and 3/29/25 at 9:46 p.m., which all indicated there were no complaints of pain or discomfort after the fall. A QMA Incident Note, dated 5/8/25 at 11:40 p.m., indicated the resident was found sitting on the floor in front of the recliner. The Director of Nursing (DON) was notified and there were no visible injuries. She was assisted off the floor and had no complaints of pain. There was no documented assessment of the resident after the fall by a Licensed Nurse. During an interview on 5/29/25 at 10:30 a.m.,			

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	Executive Director (ED) 4 indicated a Licensed Nurse was to assess a resident after a fall. A post-fall policy, undated and received from DON 2 on 5/30/25 at 11:53 a.m. as current, indicated after a fall, a nurse was to be immediately notified. Only a qualified licensed nurse was to attempt to move the resident or get the resident off the floor. The resident was to be assessed by a licensed nurse for any injuries related to the fall. The resident could be assisted to the chair or bed after the assessment from the licensed nurse was completed. Vital signs were to be checked at the time of the fall. The assessment, vital signs, the time and date of the fall, any first aid given and family/physician notification was to be documented in the Progress Notes. Post-fall documentation in the Progress Notes was to be completed every shift for three days, which should include any first aid, vital signs, any complaints of pain and other pertinent information. c. During an interview on 5/27/25 at 6:48 p.m., CNA 8 indicated she had given Resident C a shower, "last week". She was new to the facility and was unsure of the resident's shower schedule. During an interview on 5/29/25 at 11:11 a.m., a resident family member and the Memory Care Coordinator were in the room. The family member indicated the resident just received a shower, but had not received a shower on 5/27/25 and had not received a shower since 5/24/25. The resident had not received showers twice a week as scheduled. The shower schedules were reviewed on 5/30/25 at 8:00 a.m. The resident's scheduled showers were to be Tuesday and Friday on day shift.			

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	The shower logs, dated March 2025, April 2025, and May 2025, indicated she received showers on March 25, 26, and 28, April 2, 6, 7, 19, 20, 21, 28, and May 3, 13, 19, 22, 28, and 29, 2025. 2. Resident D's record was reviewed on 5/29/25 at 9:43 a.m. The diagnoses included, but were not limited to, dementia. A Service Plan, dated 4/3/25, indicated there was a fall without injuries. The interventions included the nurse would be notified after a fall and changes in the range of motion would be evaluated. A Change of Condition Level of Care assessment, dated 4/5/25, indicated a history of falls if she ambulated unassisted. Assistance of one person was required for transfers and ambulation and she was alert and oriented to person, place, and time. A QMA Progress Note, dated 4/19/25 at 12:26 p.m., indicated the resident was found sitting on the floor in front of the recliner in the room. She indicated she was not hurt, she was examined, vitals were stable. The DON and the Power of attorney were notified. There was no documented assessment of the resident after the fall by a Licensed Nurse. The Progress Notes indicated there was post fall follow up documentation on 4/19/25 at 11:56 p.m., 4/20/25 at 11:48 a.m., and 4/20/25 at 9:30 p.m., which all indicated there were no complaints of pain or discomfort after the fall. There were no post-fall assessments completed on 4/21/25.			

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	A QMA Progress Note, dated 4/22/5 at 6:06 p.m., indicated the resident was observed sitting on the floor at the foot of the bed. The resident had lost her balance and pulled the walker down on top of her. The Director of Nursing was called to the room and assessed the resident, who had complained of left hip pain. The resident refused to be transferred to the hospital. There was no assessment by a Licensed Nurse documented in the Progress Notes after the fall. The Progress Notes indicated post-fall assessments were completed on 4/22/25 at 9:30 p.m. and 4/23/25 at 9 p.m. During an interview on 5/29/25 at 10:30 a.m., ED 4 indicated a Licensed Nurse was to assess the resident after a fall. 3. Resident E's record was reviewed on 5/29/25 at 11:23 a.m. The diagnoses included, but were not limited to, dementia. A Quarterly Level of Care assessment, dated 2/27/25, indicated the resident was independent with transfers and mobility and required cognitive assistance with minimal supervision with familiar situations. An Indiana Department of Health (IDOH) Incident Report, dated 3/20/25 at 8:01 p.m., indicated the resident was found in a parking lot at the hospital located adjacent to the facility. She was admitted into the Emergency Room for an evaluation. The preventive measures included, the resident would be transferred to the Memory Care Unit upon return to the facility.			

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	A QMA Progress Note, dated 3/21/25 at 10:26 p.m., indicated the resident was transferred to the Memory Care Unit for safety precautions. A Service Plan, dated 3/22/25, indicated a history of elopement. The interventions included the resident's location would be observed in the community. During an interview on 5/29/25 at 2:57 p.m., DON 1 indicated the resident returned from the hospital on 3/20/25 night shift and was not moved to the Memory Care Unit until 3/21/25. She indicated the resident was supposed to be placed on hourly supervision until she was transferred. She was unable to locate any hourly monitoring completed by the staff. A facility missing resident/elopement policy, dated 6/29/2018 and received as current from DON 1, indicated interventions that may be used for residents who were identified as high risk for elopement included frequent monitoring of the resident's location, 30 minute visual checks. After a missing resident was found, the service plan was to be updated with new/revised safety interventions. Additional measure such as electronic surveillance device and/or 15 minute visual safety checks were to be complete for 24-hours and continued as ordered by the healthcare provider. Safety checks were to be documented in the resident record for the duration of the increased supervision. 4. Resident F's record was reviewed on 5/29/25 at 11:47 a.m. The diagnoses included, but were not limited to, dementia.			

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	A Quarterly Level of Care assessment, dated 5/8/25, indicated total assistance from staff was required for bathing, grooming, dressing, and transferring. Showers were to be provided two times a week, extensive cognitive impairment was present, there were no behaviors, and no problematic behavior. a. A Service Plan, dated 8/6/24, indicated the resident was resistive to care daily. The interventions included the resistive behavior was to be de-escalated by redirecting the behaviors. An Indiana Department of Health (IDOH) Incident Report, dated 4/17/25 at 10:01 a.m., indicated the resident reported to multiple staff that Terminated CNA 10 hit her on top of the head and slapped her face. A written statement, dated 4/18/25 and signed by Terminated CNA 10, indicated on 4/17/25 care was being provided. The resident was covered in feces. The resident agreed to the care, then started to hit the staff. She was asked to stop hitting and she replied no. She continued to keep hitting the staff. The resident was washed and dressed and continued to fight the staff. During an interview on 5/29/25 at 4 p.m., DON 1 indicated Terminated CNA 10 should have stopped the care when the resident was resistive and reported the behavior to the nurse. b. A Service Plan, dated 5/8/25, indicated the resident was to be assisted with showers two times a week. The shower schedules were reviewed on 5/30/25 at 8:00 a.m. and the resident was scheduled for showers on Wednesday and Saturday evenings.			

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		A. BUILDING 00 B. WING	06/02/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
BRENTWOOD AT HOBART	1420 ST MARYS CIRCLE HOBART, IN 46342

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	The Shower Logs, dated March 2025, April 2025, and May 2025, indicated showers had not been received after March 21, 2025. Showers were received only on April 1, 14, 25, and 21, and May 1, 7, 10, 14, 20, 21, and 24, 2025. 5. Resident H's record was reviewed on 5/29/25 at 2:09 p.m. The diagnoses included, but were not limited to, Alzheimer's disease. A Fall Risk Assessment, dated 2/6/25, indicated a high risk for falls. A Quarterly Level of Care assessment, dated 3/21/25, indicated minimal assistance was required for activities of daily living and the resident was forgetful. A Service Plan, dated 9/7/23 and revised on 5/13/25, indicated a risk for falls. The interventions included reminders would be given to use assistive devices and to use the call device. During an observation and interview on 5/29/25 at 8:36 a.m., Resident H was lying in bed and awake. There was a bruise/discoloration around the right eye. The resident's Private Caregiver indicated the resident had a fall about 5:00 a.m. approximately a week ago. A Nurse's Progress Note, dated 5/22/25 at 8:26 a.m., indicated the resident had fallen in the morning and there was a skin discoloration of the right side of the forehead. There were no complaints of pain or discomfort. There were post-fall assessments completed on 5/24/25 at 3:23 a.m., 5/24/25 at 2:11 p.m. and			

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	5/26/25 at 1:02 p.m. There was a lack of documentation that indicated the resident had fallen and an assessment had been completed by a Licensed Nurse on 5/22/25 in the early morning. The post-fall assessments had not been completed every shift for three days. During an interview on 5/29/25 at 2:43 p.m., DON 1 indicated the nurse on duty notified her about the fall and was informed the resident needed to be assessed. 6. Resident M's record was reviewed on 5/30/25 at 10:14 a.m. The diagnoses included, but were not limited to, dementia. A Quarterly Level of Care assessment, dated 3/19/25, indicated meals were served in the apartment, intake required monitoring and preparation of all meals. Verbal redirection was required and he had mild to moderate disorientation. a. During an observation on 5/28/25 at 11:55 a.m., Resident M was lying in bed with his eyes closed. A Styrofoam food container was on the kitchen table in the room. At 12:21 p.m., the resident remained asleep and the food container was unopened on the table. At 1:13 p.m., the resident remained asleep. The container of food remained untouched on the table. During an observation and interview on 5/28/25 at 1:26 p.m., the resident was sitting at the table visiting with a family member, who had brought soup for the resident. Resident M indicated he was upset because the staff had not awakened him when his meal was delivered and now his meal			

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	was cold. He indicated he did not want his food warmed up and he would eat the soup his family brought to him. During an interview on 5/28/25 at 1:30 p.m., Dietary Aide (DA) 7 indicated he delivered the lunch meal around 11:55 a.m. and the resident was sleeping. He had tried to wake him up but could not get him awake. During an interview with the Memory Care Director on 5/28/25 at 1:35 p.m., she indicated the Dietary Aides had delivered the room trays for the past three years. She was unsure why the Dietary Aides delivered and set up the meals instead of the nursing staff. During an interview and observation on 5/29/25 at 8:20 a.m., a family member was in the room and indicated she arrived at the facility around 8:00 a.m. and the resident's breakfast was in a Styrofoam container on the table and the resident had not been awakened to eat his meal. She indicated she had to wake the resident up to eat and he does not like cold food. During an observation on 5/29/25 at 12:05 p.m., the lunch meal was delivered by DA 7 to the resident's room. A Styrofoam container was placed on the table in the room. DA 7 indicated he informed the resident the meal was on the table and then indicated he could not get the resident to wake up. At 12:10 p.m., CNA 11 entered the room and assisted the resident out of bed for his meal. A Service Plan, dated 11/29/24, indicated a potential for a nutritional problem related to a decrease in appetite. The interventions included, the staff would stay with the resident during the			

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	meal to assist him as needed. A Service Plan, dated 11/29/24, indicated all meals were consumed in his room. The interventions included intake would be monitored and all meals would need to be prepared by the staff. b. A written note to the Nurse Practitioner/Physician, dated 5/14/25 and found in a three ring binder in the Assisted Living Nurses' Station, indicated the resident was refusing to take the Flomax (calcium supplement) on the evening shift and he stated the physician said not to take it. A Nurse Practitioner's Order, written on 5/14/25, indicated laboratory tests of complete blood count, comprehensive metabolic panel, and a urinalysis with culture and sensitivity if indicated due to an altered mental status and increased urgency. There was no documentation/assessment in the record to indicate a change in mental status or increased urgency. During an interview on 5/30/25 at 10:50 a.m., QMA 6 indicated she was unable to find an assessment related to the altered mental status and urgency in the record. During an interview on 5/30/25 at 12:00 p.m., ED 4 indicated a change in status was to be assessed and documented in the record. The above information was discussed with ED 4 and the Administrator in Training on 5/30/25 at 12:40 p.m. During an interview on 6/2/25 at 9:05 a.m., DON 1			

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	and DON 2 indicated there was no further information on the above findings. This citation relates to Complaints IN00458361, IN00458602, IN00458769, IN00458913, IN00458959, and IN00459996.			
R 0241 Bldg. 00	410 IAC 16.2-5-4(e)(1) Health Services - Offense Based on observation, record review and interview, the facility failed to ensure a resident received medications as ordered by the physician and failed to ensure medications were administered by a licensed nurse or qualified medication aide, for 2 of 6 residents reviewed for medications. (Residents G and L) Findings include: 1. During a medication administration pass observation on 5/27/25 at 3:55 p.m., RN 3 prepared Resident L's medications of colestevelam hydrochloride (cholesterol medication), 625 milligrams (mg), three tablets and atrovastin (cholesterol medication), 80 mg, one tablet. Resident L indicated she needed to take the medication with her meal, placed the medication cup with the medications in her walker and ambulated to the dining room. RN 3 continued to administer medications to other residents. During an observation on 5/27/25 at 4:30 p.m., Resident L was in the dining room and had finished eating and was taking the medications. The medications were not administered by the licensed nurse. Resident L's record was reviewed on 5/30/25 at	R 0241	Resident G and Resident L were assessed and found to be free of negative effects. All residents have the potential to be affected. An audit was conducted on all current residents. No further residents were identified as being affected. The RDO educated the ED and DON on the requirement for residents to receive medications as ordered by the physician and administered by a licensed nurse of qualified medication aide. The DON/Designee will conduct monthly random medication pass audits to ensure medications are being administered by a licensed nurse or qualified medication aide. The DON/Designee will review the MAR five times per week ensure appropriate documentation for all entries in the MAR. Results of the audits will be reviewed at the facility monthly QA meeting. The Executive Director/designee is responsible for sustained compliance. ="" p="">	06/20/2025

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	9:50 a.m. The diagnoses included, but were not limited to mild cognitive impairment and rheumatoid arthritis. A Quarterly Level of Care assessment, dated 4/3/25 indicated medication assistance was required. The nursing staff were to monitor and administer medications due to cognitive loss. A Service Plan, dated 6/24/24, indicated the resident was unable to self-administer medications related to cognitive impairment. The interventions indicated a licensed or certified staff member would administer the medications. An undated facility self-administration of medication procedure, received from DON 2 (Director of Nursing) on 5/30/25 at 11:53 a.m. as current, indicated the physician was to indicate if the resident was capable and competent of self-administration and the resident was to be assessed by the facility to ensure the resident was able to self-administer the medications. Executive Director (ED) 4 and the Administrator in Training were informed of the observation on 5/30/25 at 12:40 p.m. During an interview on 6/2/25 at 9:05 a.m., DON 1 provided no further information. 2. Resident G's record was reviewed on 5/29/25 at 1:40 p.m. The diagnoses included, but were not limited to, stroke. A Service Plan, dated 9/24/24, indicated daily supervision of medication was required. A Quarterly Level of Care assessment, dated			

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	3/23/25, indicated medications were administered per the nursing staff. The current Physician's Orders indicated the following: On 9/5/24, acetaminophen 325 milligrams (mg), give two tablets three times a day. On 12/28/23, sodium chloride (supplement) 1 gram (gm), give one tablet three times a day. On 12/8/23, Lisinopril (anti-hypertensive) 10 mg, give one tablet three times a day. On 3/15/25, Aspercreme patch (pain patch) 4%, apply one patch every day to the right back, on 12 hours and off 12 hours. The Medication Administration Record (MAR), dated 4/2025, indicated the acetaminophen, sodium chloride, Lisinopril had not been administered on April 7, 2025 at 1:00 p.m. The MAR, dated 5/2025, indicated the acetaminophen, sodium chloride, Lisinopril, and Aspercreme patch had not been given on May 27, 2025 at 1:00 p.m. During an interview on 5/29/25 at 2:43 p.m., Director of Nursing (DON) 1 provided no further information in regards to the missed medication. This citation relates to Complaints IN00457244 and IN00458361.			
R 0349 Bldg. 00	410 IAC 16.2-5-8.1(a)(1-4) Clinical Records - Noncompliance Based on record review and interview, the facility	R 0349	Resident F and Resident C were	06/20/2025

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	failed to ensure medical records were complete and accurate related to documentation of an allegation of abuse and documentation that a shower had been completed when it had not been, for 2 of 11 residents reviewed for clinical records. (Residents C and F) Findings include: 1. During an interview on 5/27/25 at 6:48 p.m., CNA 8 indicated a shower had not been given to Resident C that evening. Resident C's record was reviewed on 5/28/25 at 3:15 p.m. The diagnoses included, but were not limited to, dementia, stroke, history of falls, and legal blindness. A Service Plan, dated 9/19/24, indicated assistance was required and provided for bathing. A Quarterly Level of Care assessment, dated 4/3/25 at 5:59 p.m., indicated moderate assistance was required for bathing twice a week by a caregiver, moderate assistance was required for all activities of daily living (ADL's), the staff were to set up items, cue and use hands on assistance. Assistance was required for sight related needs, and required verbal re-direction. The Medication Administration Record, dated 5/2025, indicated a shower had been given on 5/27/25 evening. During an interview on 5/28/25 at 3:42 p.m., LPN 18 indicated she had signed that the shower had been given on 5/27/25 because she had overheard the CNA's talking and they had said they were happy the resident took a shower.		assessed and found to be free of negative effects. All residents have the potential to be affected. An audit was completed for all current residents. No further residents were identified as being affected. The RDO educated the ED and DON on the requirement to ensure medical records were complete and accurate related to documentation of abuse allegations and ADL care. The DON/designee educated all nursing staff on the policy/procedure of documenting ADL care refusals. The DON/Designee will audit 5 residents weekly times 12 weeks to ensure information documented in the medical record is complete and accurate. The ED/Designee will review the medical records to ensure complete and accurate documentation is present in the medical record following any abuse allegation. Results of the audits will be reviewed at the facility monthly QA meeting. The Executive Director/designee is responsible for sustained compliance. ="" p="">	

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	During an interview on 5/29/25 at 9:30 a.m., CNA 8 indicated a shower had not been given on 5/27/25 because the resident had refused and the QMA had been notified. During an interview on 5/29/25 at 2:43 p.m., Director of Nursing (DON) 1 indicated the documentation was incorrect. 2. Resident F's record was reviewed on 5/29/25 at 11:47 a.m. The diagnoses included, but were not limited to, dementia. An Indiana Department of Health (IDOH) Incident Report, dated 4/17/25 at 10:01 a.m., indicated the resident reported to multiple staff that Terminated CNA 10 hit her on top of the head and slapped her face. There was no documentation in the resident record in regard to the allegation of abuse. During an interview on 5/29/25 at 4:00 p.m. , DON 1 indicated the allegation had not been documented in the clinical record. This citation relates to Complaints IN00458769, IN00458913, IN00458959, and IN00459996.			
R 0354 Bldg. 00	410 IAC 16.2-5-8.1(g)(1-7) Clinical Records - Noncompliance Based on record review and interview, the facility failed to ensure a resident who discharged to another healthcare facility received a transfer form with information for continuity of care, for 1 of 3 residents reviewed for discharge/transfer. (Resident J)	R 0354	All residents have the potential to be affected. An audit was completed for discharges within the past 30 days to ensure a transfer form was completed with information for continuity of care. No other residents were identified	06/20/2025

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	Finding includes: Resident J's record was reviewed on 5/29/25 at 2:29 p.m. The diagnoses included, but were not limited to anxiety, depression, and hypertension. A Nurse's Progress Note, dated 4/26/25 at 5:22 p.m., indicated the resident was being discharged to another facility. The Power of Attorney (POA) signed the proper documents and all personal belongings were taken. There was a lack of documentation a transfer form was provided to the receiving facility which included, but was not limited to, functional abilities, physical limitations, nursing care, medications, treatments, diagnoses, diet, and other information for continuity of care. During an interview on 5/29/25 at 2:43 p.m., Director of Nursing (DON) 1 indicated the POA wanted the resident transferred and a transfer form and reason for the discharge should have been documented. This citation relates to Complaint IN00458959.		as being affected. The RDO educated the ED and DON on the requirement of providing a transfer form when a resident is being discharged to another healthcare facility. The DON provided education to the nursing staff on the requirement of completing the transfer form. The DON/Designee will complete a weekly audit for those residents who were identified as being discharged to another healthcare facility to ensure appropriate documentation and a transfer form was completed to assist with continuity of care. Results of the audits will be reviewed at the facility monthly QA meeting. The Executive Director/designee is responsible for sustained compliance. ="" p="">	