PRINTED: 08/01/2024 FORM APPROVED

Indiana Department of Health

NAME OF PROVIDER OR SUPPLIER B. WING	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION (X3 A. BUILDING:		(X3) DATE SURVEY COMPLETED	
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE			002627	B. WING		R-C 07/30/2024	
BRENTWOOD AT HOBART HOBART, IN 46342							
PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMP	PREFIX	(EACH DEFICIENC	ENCY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE	BE COMPL	LETE
{R 000} INITIAL COMMENTS {R 000}	{R 000} INI	O) INITIAL COMMENTS		{R 000}			
This visit was for a Post Survey Revisit (PSR) to Investigation of Complaint IN00434733 completed on May 22, 2024. Complaint IN00434733 - Corrected Survey dates: July 30, 2024 Facility number: 002627 Residential Census: 119 Brentwood at Hobart was found to be in compliance with 410 IAC 16.2-5 in regard to the PSR to Investigation of Complaint IN00434733. Quality review completed on 7/31/24.	Thi Inv cor Co Su Fac Re Bre cor PS	This visit was for a Palnvestigation of Completed on May 22 Complaint IN004347. Survey dates: July 30 Facility number: 0026 Residential Census: Brentwood at Hobart compliance with 410 PSR to Investigation	a Post Survey Revisit (PSR) to omplaint IN00434733 / 22, 2024. 44733 - Corrected 7 30, 2024 02627 us: 119 eart was found to be in 10 IAC 16.2-5 in regard to the on of Complaint IN00434733.	(IX 000)			

Indiana Department of Health

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE (X6) DATE