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	01/31/2024

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 IN00421009 and IN00426601. Complaint IN00421009 - No deficiencies related to the allegations are cited. Complaint IN00426601 - State deficiencies related to the allegations are cited at R240 and R349. Unrelated deficiencies are cited. Survey dates: January 30 and 31, 2024. Facility number: 002627 Residential Census: 119 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review completed on 2/7/24.	R 0000		
R 0120 Bldg. 00	410 IAC 16.2-5-1.4(e)(1-3) Personnel - Noncompliance (e) There shall be an organized inservice education and training program planned in advance for all personnel in all departments at least annually. Training shall include, but is not limited to, residents' rights, prevention and control of infection, fire prevention, safety, accident prevention, the needs of specialized populations served, medication administration, and nursing care, when appropriate, as follows: (1) The frequency and content of inservice education and training programs shall be in accordance with the skills and knowledge of			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Sandra Williams	Executive Director	02/19/2024

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.

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	01/31/2024

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
	the facility personnel. For nursing personnel, this shall include at least eight (8) hours of inservice per calendar year and four (4) hours of inservice per calendar year for nonnursing personnel. (2) In addition to the above required inservice hours, staff who have contact with residents shall have a minimum of six (6) hours of dementia-specific training within six (6) months and three (3) hours annually thereafter to meet the needs or preferences, or both, of cognitively impaired residents effectively and to gain understanding of the current standards of care for residents with dementia. (3) Inservice records shall be maintained and shall indicate the following: (A) The time, date, and location. (B) The name of the instructor. (C) The title of the instructor. (D) The names of the participants. (E) The program content of inservice. The employee will acknowledge attendance by written signature. Based on record review and interview, the facility failed to ensure annual dementia training had been completed for 2 of 3 employees reviewed. (CNA 1 and CNA 2) Finding includes: The employee records and inservices were reviewed 1/31/24 at 10:50 a.m. CNA 1 was hired on 5/1/23. He had only attended two inservices related to dementia training within 6 months of hire. CNA 2 was hired on 5/1/23. She had only attended one inservice related to dementia	R 0120	Administrator ordered Positive Approach to Care Progression of Dementia with Teepa Snow The Journey of Dementia with Teepa Snow and It's all in your approach with Teepa Snow. All staff to be scheduled for dementia training with videos. Staff will have state required hours on or before March 31,2024. Relias training will also be updated with monthly in services trainings/modules monthly. New hires will be trained before	03/31/2024

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	01/31/2024

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
	training within 6 months of hire. During an interview, on 1/31/24 at 11:33 a.m., the Administrator indicated the dementia training had not been completed.		floor orientation.	
R 0217 Bldg. 00	410 IAC 16.2-5-2(e)(1-5) Evaluation - Deficiency (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 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 resident service plans were	R 0217	Director of nursing and ADON to audit service plans monthly for	02/29/2024

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	01/31/2024

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
	completed and signed by the resident or resident's representative, for 2 of 5 service plans reviewed. (Residents C and E) Findings include: 1. Resident C's record was reviewed on 1/30/24 at 9:35 a.m. The Resident Level of Care Assessment was completed on 12/26/23. There was no Service Plan associated with the assessment and was not signed by the resident and/or responsible party. 2. Resident E's record was reviewed on 1/31/24 at 8:25 a.m. The Resident Level of Care Assessment was completed on 11/1/23. There was no Service Plan associated with the assessment and was not signed by the resident and/or responsible party. During an interview with the Administrator, on 1/30/24 at 1:40 p.m., she indicated the assessments should have generated a Service Plan. She was not aware the Service Plans were missing. They were to be completed quarterly and as needed, then a copy provided to the resident or family.		three months to ensure all service plans are updated accordingly. All service plans will coincide with resident's ADL functioning and services needed. All service plans will have responsible party signatures when updated. Monthly/Quarterly audits indefinitely.	
R 0240 Bldg. 00	410 IAC 16.2-5-4(d) Health Services - Deficiency (d) Personal care, and assistance with activities of daily living, shall be provided based upon individual needs and preferences. Based on record review and interview, the facility failed to ensure dependent residents received the necessary ADL (activities of daily living) assistance, related to showers as scheduled, for 3 of 3 residents reviewed for ADL care. (Residents B, C and F)	R 0240	Director of Nursing and ADON will audit shower sheets weekly to ensure showers are given. Shower task placed on Emar to document shower completion.	02/29/2024

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	01/31/2024

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
	Findings include: 1. The record for Resident B was reviewed on 1/30/24 at 10:08 a.m. Diagnoses included, but were not limited to, unspecified dementia and hypertension. She resided on the memory care unit. A Resident Assessment, dated 12/15/23, indicated the resident required full assistance for bathing two times a week. Shower sheets for December 2023 and January 2024 indicated showers were given on the following dates: 12/5/23 12/12/23 12/15/23 12/22/23 12/26/23 12/29/23 1/2/24 1/5/24 1/9/24 1/12/24 1/26/24 2. The record for Resident C was reviewed on 1/30/24 at 9:35 a.m. Diagnoses included, but were not limited to, unspecified dementia and depression. The resident resided on the memory care unit. A Resident Assessment, dated 12/26/23, indicated the resident required prompting and cueing and bathing set up. There was no frequency specified. Shower sheets for December 2023 and January 2024 indicated showers were given on the		Kiosk will be installed for documentation of nursing assistant ADL charting.	

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	01/31/2024

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
	following dates: 12/5/23 12/12/23 12/15/23 12/22/23 12/25/23 12/30/23 1/12/24 1/19/24 1/23/24 1/27/24 3. The record for Resident F was reviewed on 1/30/24 at 2:00 p.m. The resident was admitted on 1/12/24. Diagnoses included, but were not limited to, unspecified dementia, a history of falls and depression. The resident resided on the memory care unit. A Service Plan, dated 1/12/24, indicated the resident was unable to bathe herself and required assistance two times a week. Shower sheets for January 2024 indicated showers were given on the following dates: 1/14/24 1/18/24 1/27/24 During an interview with the Director of Nursing, on 1/30/24 at 1:35 p.m., she indicated all residents should be showered twice weekly and then documented on a shower sheet. If they refused, this should also be documented. This citation relates to Complaint IN00426601.			
R 0275 Bldg. 00	410 IAC 16.2-5-5.1(h) Food and Nutritional Services - Deficiency (h) Diet orders shall be reviewed and revised			

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	01/31/2024

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
	by the physician as the resident ' s condition requires. Based on record review and interview, the facility failed to ensure Physician Orders for a diet were in place for 2 of 5 residents reviewed. (Residents C and D) Findings include: 1. The record for Resident C was reviewed on 1/30/24 at 9:35 a.m. Diagnoses included, but were not limited to, unspecified dementia and depression. The resident resided on the memory care unit. There was no Physician's Order in place for a diet. 2. The record for Resident D was reviewed on 1/30/24 at 2:20 p.m. Diagnoses included, but were not limited to, bipolar disorder, depression and anxiety. There was no Physician's Order in place for a diet. On 1/30/24 at 3:35 p.m., the Executive Director was made aware there were no diet orders in place for the residents. No additional information was provided.	R 0275	Administrator and director of nursing completed facility diet order audit on 2/2/2024 at this time facility has diet orders for all residents. Diet orders were completed and signed per MD for every resident. Director of nursing will audit monthly and upon new admissions indefinitely.	02/29/2024
R 0349 Bldg. 00	410 IAC 16.2-5-8.1(a)(1-4) Clinical Records - Noncompliance (a) The facility must maintain clinical records on each resident. 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.			

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	01/31/2024

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
	(4) Systematically organized. Based on record review and interview, the facility failed to ensure clinical records were accurate and complete, related to lack of documentation of a discoloration of unknown origin on a resident's hand, for 1 of 1 residents reviewed for injury of unknown origin. (Resident B) Finding includes: Resident C's record was reviewed on 1/30/24 at 10:08 a.m. Diagnoses included, but were not limited to, unspecified dementia and hypertension. The resident resided on the memory care unit. A Health Status Note, dated 10/16/23, indicated the resident had discoloration to the left hand with no signs of pain. A Health Status Note, dated 10/17/23, indicated the resident had discoloration to the left hand with no complaints voiced by the resident. The October 2023 shower sheets lacked documentation there were any skin concerns such as bruising or open areas. The 72-hour Nursing Reports indicated the resident had a discoloration on her left hand on 10/17, 10/18 and 10/19/23. There was no documentation what sort of discoloration, observed color, measurements, or how the discoloration occurred. During an interview with the Executive Director (ED), on 1/30/24 at 3:35 p.m., she indicated the documentation should have been more specific. If it was a bruise of unknown origin, it should have been reported to the ED or Director of Nursing and they would have investigated.	R 0349	Director of nursing and ADON to audit charting regarding skin issues weekly for three months then monthly for three months. Director of nursing has educated all nursing on how and when to report skin issues. Director of nursing and ADON to audit shower sheets and skin sheets weekly.	02/29/2024

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	01/31/2024

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
	This citation relates to Complaint IN00426601.			