PRINTED: 09/14/2022 FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY			
AND PLAN OF CORRECTION IDENTIFICATION NUMBER		A. BUILDING <u>00</u>		00	COMPLETED		
		B. WING		08/18/2022			
				CTDEET	ADDRESS, CITY, STATE, ZIP COD	<u> </u>	
NAME OF P	ROVIDER OR SUPPLIE	₹			T MARY'S CIRCLE		
BRENTWOOD AT HOBART					RT, IN 46342		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
R 0000							
Distr. 00							
Bldg. 00	Tl.::-:4 £ 41	I	D 00	000	This Disas of Commention is made		
	IN00387249 and IN	ne Investigation of Complaints	R 0000		This Plan of Correction is not to be		
	1110036/249 aliu 11	N00388009.			construed as an admission of or agreement with the findings and		
	Complaint IN0038	7249 - Substantiated. State					
	_	o the allegations is cited at			conclusions in the Statement of Deficiencies. This plan of		
	R0090.	o the unegations is effect at			correction is being submitted as		
					required by the regulation. On		
	Complaint IN00388	8069 - Unsubstantiated due to			09/03/2022 the Administrator,		
	lack of evidence.				oversight from the Regional Vi		
					President of Operations and		
	Survey date: Augu	st 18, 2022			Regional Nurse Consultant wil	I	
					ensure all corrective action in	the	
	Facility number: 0	02627			following POC has been		
					completed.		
	Residential Census	: 101					
	Th:- C4-4- D: 1	dal Piadia a la citad la					
	accordance with 41	tial Finding is cited in					
	accordance with 41	0 IAC 10.2-3.					
	Quality review com	npleted on 8/22/22.					
R 0090	R 0090 410 IAC 16.2-5-1.3(g)(1-6)						
		d Management - Deficiency					
Bldg. 00		ator is responsible for the					
	overall manageme	ent of the facility. The					
		the administrator shall					
	include, but are n	ot limited to, the following:					
	(1) Informing the	division within twenty-four					
	(24) hours of become	oming aware of an unusual					
	occurrence that d	irectly threatens the					
	welfare, safety, or	health of a resident. Notice					
		ence may be made by					
	•	ed by a written report, or by					
		nly that is faxed or sent by					
		the division within the					
	twenty-four (24) hour time period. Unusual						
	occurrences inclu	de, but are not limited to:					
			<u> </u>				l .

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

TITLE

(X6) DATE

Any defiency statement 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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STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY		
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER	a. building <u>00</u>		COMPLETED		
		B. W	B. WING			08/18/2022	
		<u> </u>		STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF PROVIDER OR SUPPLIER					T MARY'S CIRCLE		
BRENTWOOD AT HOBART			HOBART, IN 46342				
					T		
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIE		ID PREFIX		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
PREFIX TAG	(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION			TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		TE	COMPLETION DATE
IAU	(A) epidemic outb			IAU			DATE
	(B)poisonings;	reaks,					
	(C) fires; or						
	(D) major acciden	te					
		not be reached, a call shall					
		nergency telephone number					
	published by the o						
		nging for or assisting with					
	. ,	edical, dental, podiatry, or					
	-	her health care services as					
	requested by the	resident or resident's legal					
	representative.						
	(3) Obtaining dire	ctor approval prior to the					
	admission of an ir	ndividual under eighteen (18)					
	years of age to an						
		acility maintains, on the					
	•	urate record of actual time					
	worked that indica						
	(A) employee's ful						
	, ,	rs worked during the past					
	twelve (12) month						
	, ,	sults of the most recent					
	•	the facility conducted by					
		ny plan of correction in					
	effect with respect to the facility, and any						
	•	ys. The results must be					
		nination in the facility in a essible to residents and a					
	notice posted of the						
	-						
	(6) Maintaining reports of surveys conducted						
	by the division in each facility for a period of two (2) years and making the reports						
	available for inspection to any member of the						
	public upon request						
		view and interview, the facility	R 0	090	1.What correction action w	ill	08/26/2022
		allegation of abuse was			be accomplished for those		
	reported to the Indiana Department of Health				residents found to have beer	1	
	(IDOH) timely for 2	2 of 3 sampled residents			affected by the deficient		
	reviewed. (Residents C and D)				practice?		
					2.The Executive Director as	well	
J			1		I		

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	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE C A. BUILDING B. WING	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 08/18/2022		
NAME OF PROVIDER OR SUPPLIER BRENTWOOD AT HOBART			STREET ADDRESS, CITY, STATE, ZIP COD 1420 ST MARY'S CIRCLE HOBART, IN 46342				
(X4) ID PREFIX TAG	X (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFIX TAG	TION (X5) LD BE ROPRIATE COMPLETIC DATE	ON		
	Finding includes: An IDOH reportabindicated on 7/29/2 observed Resident take the creamer ar Resident D denied opened Resident D knew he was taking Resident C on the a Interview with the p.m., indicated the afternoon on 7/29/2 had been notified building and was made in She should have rebeing informed of the A facility policy, tinglect," indicated Executive Director following:2. Progreguired by law"	le incident, dated 8/1/22, 2 at 3:58 p.m. staff had C telling Resident D not to d sugar off the tables. taking them. Resident C s walker seat to show she at them. Resident D then hit term. Administrator on 8/18/22 at 2:54 incident had occurred in the e.2, which was a Friday. She y staff but was out of the ot able to report the incident. The incident on Monday 8/1/22. Sported it within 24 hours of		as department leaders reducation to follow Clinical Policy: GP 10 – Resident Neglect, and Exploitation the Executive Director is responsible to ensure includent is reported per state regard laws. The Executive is responsible to ensure the incident is reported per state regulations and laws follow Indiana State Department Health Reportable Incident dated 07/15/2015. The Exporting of Director received additional education to follow Clinical GP 19-Internal and State Reporting. The Executive or their designee will ensurable appropriate state agencies notified by following the Instate Department of Heal Reportable Incident Policio 07/15/2015. The Executive Director or their designee promptly report all requires incidents to the Corporate person per the "When to Protocol." A copy of the State Department of the Incident Report for any state person per the "When to Protocol." A copy of the State Department of the Incident Regional Vice Preside Operations and Regional Consultant immediately to oversight and monitoring Executive Director reportion incidents timely. 1. How will the communicating other residents the potential to be affect.	ceived all Abuse, in which idents gulations Director he ate wing the t of at Policy executive hal all Policy: Incident e Director ure all es are adiana atth y dated ve will ed e Staff Call State ate e sent to ent of Nurse o ensure of the ang anity having		

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	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CO A. BUILDING B. WING	onstruction 00	(X3) DATE SURVEY COMPLETED 08/18/2022		
NAME OF PROVIDER OR SUPPLIER BRENTWOOD AT HOBART			STREET ADDRESS, CITY, STATE, ZIP COD 1420 ST MARY'S CIRCLE HOBART, IN 46342				
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	DATE		
				the same deficient practice what corrective action will be taken? All residents of the community have the potentic to be affected. The Executive Director or their designee we ensure all appropriate state agencies are notified by following the Indiana State Department of Health Reportable Incident Policy dated 07/15/2015. The Regional Vice President of Operations and Regional Nuc Consultant will ensure oversight and monitoring of Executive Director reporting incidents timely. 1. What measures will be president of the place or what systemic changes will the community make to ensure the deficient practice does not recur 2. The Executive Director of their designee will promptly report all required incidents the Corporate Staff person of the "When to Call Protocol." copy of the State Incident Report for any state reportation incident will be sent to the Regional Vice President of Operations and Regional Nuc Consultant immediately to ensure oversight and monitoring of the Executive Director reporting incidents timely to ISDH. 1. How will the corrective	e al ve al ve ill la ve il		

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	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CO A. BUILDING B. WING	onstruction 00	(X3) DATE SURVEY COMPLETED 08/18/2022		
NAME OF PROVIDER OR SUPPLIER BRENTWOOD AT HOBART			STREET ADDRESS, CITY, STATE, ZIP COD 1420 ST MARY'S CIRCLE HOBART, IN 46342				
(X4) ID PREFIX TAG	(EACH DEFICIE	Y STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	(X5) COMPLETION DATE		
				action(s) be monitored to ensure the deficient practic will not recur, i.e., what qua assurance program will be into place? 2. The Executive Director of designee will monitor incident reports daily and will promptly report all required incidents to the Corporate Staff person postate reportable incident will sent to the Regional Vice President of Operations and Regional Nurse Consultant immediately to ensure oversiand monitoring of the Execut Director reporting incidents to ISDH. Monthly, the Region Nurse Consultant reviews an audits all incident reports to ensure compliance to the Incident Policy days what date the system changes will be completed: 4. All corrective actions will completed by 9/3/2022.	e allity put r their tt y o er the opy of any be ght tive imely nal id diana ated		

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