

Indiana State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 002627	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 10/27/2022
--	---	---	---

NAME OF PROVIDER OR SUPPLIER BRENTWOOD AT HOBART	STREET ADDRESS, CITY, STATE, ZIP CODE 1420 ST MARY'S CIRCLE HOBART, IN 46342
--	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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) COMPLETE DATE
R 000	<p>INITIAL COMMENTS</p> <p>This visit was for a Quality Assurance Walk Through Survey.</p> <p>Survey date: October 27, 2022</p> <p>Facility number: 002627</p> <p>Residential Census: 83</p> <p>Brentwood at Hobart was found to be in compliance with 410 IAC 16.2-5 in regard to the Quality Assurance Walk Through Survey.</p> <p>Quality review completed on 10/28/22.</p>	R 000		

Indiana State Department of Health LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
---	-------	-----------