STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING B. WING	01/16/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRENTWOOD AT LAPORTE	2002 ANDREW AVE, LA PORTE, , 46350

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES...	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION...	(X5) COMPLETION DATE
R 0000	INITIAL COMMENTS This visit was for a State Residential Licensure Survey. Survey dates: January 15 and 16, 2025 Facility number: 010890 Residential Census: 96 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review completed on 1/21/25.	R 0000	This Plan of Correction is not to be construed as an admission of, or agreement with the findings and conclusions in the statement of deficiencies. This Plan of Correction is being submitted as required by the regulation. We respectfully request a desk review in this matter.	
R 0092	Administration and Management - Noncompliance 410 IAC 16.2-5-1.3(i)(1-2) (i) The facility must maintain a written fire and disaster preparedness plan to assure continuity of care of residents in cases of emergency as follows: (1) Fire exit drills in facilities shall include the transmission of a fire alarm signal and simulation of	R 0092	**R 092** 410 IAC 16.2-5-1.2(v)(1-6) Administration and Management- What Has Been Done ED and Maintenance director audited the fire drills for the year and	02/23/2025

	emergency fire conditions, except that the movement of nonambulatory residents to safe areas or to the exterior of the building is not required. Drills shall be conducted quarterly on each shift to familiarize all facility personnel with signals and emergency action required under varied conditions. At least twelve (12) drills shall be held every year. When drills are conducted between 9 p.m. and 6 a.m., a coded announcement may be used instead of audible alarms. (2) At least every six (6) months, a facility shall attempt to hold the fire and disaster drill in conjunction with the local fire department. A record of all training and drills shall be documented with the names and signatures of the personnel present. Based on record review and interview, the facility failed to ensure fire drills were conducted quarterly on each shift. This had the potential to affect all 96 residents residing in the facility. Finding includes: The annual fire drill documents were reviewed on 1/16/25. There was no fire drill conducted on the night shift during the first quarter (January, February and March) of 2024. There was no fire drill conducted on the night shift during the second quarter (April,			Nonco mplianc e	e to C or re ct ?	Mainten ance director to run addition al fire drill for night shift that was missed. Ho w Wi ll Re cu rre nc e Be Pr ev en te d? The ED and Mainten ance Director have set a rotation to ensure that each shift will be trained each quarter. ED to audit Fire Drills each month for 1 year to ensure that each	

	May and June) of 2024. During an interview on 1/16/25 at 10:38 a.m., the Administrator indicated she had no further information related to the fire drills not conducted quarterly on each shift. Based on record review and interview, the facility failed to ensure fire drills were conducted quarterly on each shift. This had the potential to affect all 96 residents residing in the facility. Finding includes: The annual fire drill documents were reviewed on 1/16/25. There was no fire drill conducted on the night shift during the first quarter (January, February and March) of 2024. There was no fire drill conducted on the night shift during the second quarter (April, May and June) of 2024. During an interview on 1/16/25 at 10:38 a.m., the Administrator indicated she had no further information related to the fire drills not conducted quarterly on each shift.		shift is being trained each Quarter. Due Date: 2/23/2025	
R 0148	Sanitation and Safety Standards - Deficiency 410 IAC 16.2-5-1.5(e)(1-4)	R 0148	410 IAC 16.2-5-1 What HVAC	02/23/2025

	(e) The facility shall maintain buildings, grounds, and equipment in a clean condition, in good repair, and free of hazards that may adversely affect the health and welfare of the residents or the public as follows: (1) Each facility shall establish and implement a written program for maintenance to ensure the continued upkeep of the facility. (2) The electrical system, including appliances, cords, switches, alternate power sources, fire alarm and detection systems, shall be maintained to guarantee safe functioning and compliance with state electrical codes. (3) All plumbing shall function properly and comply with state plumbing codes. (4) At least yearly, heating and ventilating systems shall be inspected. Based on record review and interview, the facility failed to ensure written policies were in place related to ensure facility maintenance equipment was kept in safe, working conditions, and failed to have an annual inspection of the heating ventilation system (HVAC). This had the potential to affect all 96 residents residing in the facility. Finding includes: The Survey Readiness Notebook was reviewed on		**R 148**	.2(v)(1-6) Sanitation and Safety Standards-Deficiency	Has Been Done to Correct?	inspection scheduled for 02/05/2025. How Will Recurrence Be Prevented? ED is to oversee maintenance director gets annual inspection annually. Person Responsible: ED and Maintenance Director Due Dat	

	1/16/25 at 10:30 a.m. There were no written policies included in the notebook that indicated how often fire alarms, generators, sprinklers or other mechanical systems needed to be inspected or have preventative maintenance. During an interview on 1/16/25 at 10:57 a.m., the Administrator indicated they had 14 new HVACs installed in the past year, but there was no actual inspection of the HVAC system completed in the last year. During a follow up interview on 1/16/25 at 11:54 a.m., the Administrator indicated she reached out to corporate and they did not have a policy related to HVAC inspections in place at the time, but they would now be implementing a policy. Based on record review and interview, the facility failed to ensure written policies were in place related to ensure facility maintenance equipment was kept in safe, working conditions, and failed to have an annual inspection of the heating ventilation system (HVAC). This had the potential to affect all 96 residents residing in the facility. Finding includes: The Survey Readiness Notebook was reviewed on 1/16/25 at 10:30 a.m. There were no written policies included		e: 2/23/2025	

	in the notebook that indicated how often fire alarms, generators, sprinklers or other mechanical systems needed to be inspected or have preventative maintenance. During an interview on 1/16/25 at 10:57 a.m., the Administrator indicated they had 14 new HVACs installed in the past year, but there was no actual inspection of the HVAC system completed in the last year. During a follow up interview on 1/16/25 at 11:54 a.m., the Administrator indicated she reached out to corporate and they did not have a policy related to HVAC inspections in place at the time, but they would now be implementing a policy.			
R 0217	Evaluation - Deficiency 410 IAC 16.2-5-2(e)(1-5) (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	R 0217	**R 217** 410 IAC 16.2-5-1.2(v)(1-6) Evaluation - Deficiency What Has Been Done to Correct? DON and ADON completed an audit to ensure all services	02/23/2025

	(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 Service Plans were updated timely related to hospice services and signed by the resident and/or representative for 1 of 7 resident records reviewed. (Resident 2) Finding includes: The record for Resident 2 was		How Will Recurrence Be Prevented?	DON and ADON will ensure that service plans are updated within a week of being admitted to outside services. DON will report new services on the weekly DON report to ensure that service plans are up to date	plans are up to date.	

	reviewed on 1/15/25 at 10:14 a.m. Diagnoses included, but were not limited to, Alzheimer's disease. The resident was admitted to the facility on 5/1/23. A Physician's Order, dated 10/24/24, indicated to admit to hospice. The Service Plan, dated 12/6/24 and signed by the POA (power of attorney), indicated the resident had moderate dementia with significant short-term memory and possible long-term memory loss. The Service Plan did not indicate the resident was receiving hospice services. During an interview on 12/5/24 at 9:05 a.m., the Director of Nursing (DON) indicated the resident started hospice services on 10/7/24 and she added the hospice services to the Service Plan late. A facility policy titled, "Assistance/Service Plan" indicated "...2. The Resident Assistant and Resident Services Coordinator will visit with the resident and family to develop the plan. 3. The Resident Services Coordinator will establish a schedule for services based on the assistance/service plan and inform the Resident Assistants of the assistance needs. 4. All components of the		indefinitely. DON and ADON to complete audit of all service plans biweekly for the next 90 days. Due Date: 2/23/2025	

assistance/service plan form must be completed."

Based on record review and interview, the facility failed to ensure Service Plans were updated timely related to hospice services and signed by the resident and/or representative for 1 of 7 resident records reviewed. (Resident 2)

Finding includes:

The record for Resident 2 was reviewed on 1/15/25 at 10:14 a.m. Diagnoses included, but were not limited to, Alzheimer's disease. The resident was admitted to the facility on 5/1/23.

A Physician's Order, dated 10/24/24, indicated to admit to hospice.

The Service Plan, dated 12/6/24 and signed by the POA (power of attorney), indicated the resident had moderate dementia with significant short-term memory and possible long-term memory loss. The Service Plan did not indicate the resident was receiving hospice services.

During an interview on 12/5/24 at 9:05 a.m., the Director of Nursing (DON) indicated the resident started hospice services on 10/7/24 and she added the hospice services to the Service Plan late.

	A facility policy titled, "Assistance/Service Plan" indicated "...2. The Resident Assistant and Resident Services Coordinator will visit with the resident and family to develop the plan. 3. The Resident Services Coordinator will establish a schedule for services based on the assistance/service plan and inform the Resident Assistants of the assistance needs. 4. All components of the assistance/service plan form must be completed."			
R 0241	Health Services - Offense 410 IAC 16.2-5-4(e)(1) (e) The administration of medications and the provision of residential nursing care shall be as ordered by the resident ' s physician and shall be supervised by a licensed nurse on the premises or on call as follows: (1) Medication shall be administered by licensed nursing personnel or qualified medication aides. Based on record review and interview, the facility failed to ensure physician's orders were followed related to medications not administered as ordered for 1 of 7 residents reviewed. (Resident 2)	R 0241	**R 241** 410 IAC 16.2-5-1.2(v)(1-6) Health services - Offense **What Has Been Done to Correct?** DON completed educational forms with employees who did not chart reattempts or refusals of medications. DON also in-serviced nursing	02/23/2025

	Finding includes: The record for Resident 2 was reviewed on 1/15/25 at 10:14 a.m. Diagnoses included, but were not limited to, Alzheimer's disease. The resident was admitted to the facility on 5/1/23. The Service Plan, dated 12/6/24 and signed by the POA (power of attorney), indicated the resident had moderate dementia with significant short-term memory and possible long-term memory loss. The resident required assistance with medications due to cognitive loss. A Physician's Order, dated 10/18/24, indicated sucralfate 1 gram, one tablet by mouth three times daily 30 minutes prior to meals for nausea and vomiting. A Physician's Order, dated 10/18/24, indicated ondansetron tablet four milligrams tablet, one tablet by mouth every eight hours for nausea and vomiting. The November 2024, December 2024, and January 2025 Medication Administration Records (MAR) indicated the ondansetron tablet and sucralfate tablet were coded not administered at 7:30 a.m. as resident was sleeping on the following dates: 11/6, 11/10, 11/13, 11/19, 11/20, 11/23, 11/28, 12/2, 12/8, 12/11, 12/14,		H o w W ill R ec ur re nc e B e Pr ev e nt e d ?	DON will run nursing notes daily to view all missed medications indefinitely, DON will audit missed medications weekly for 1 month, biweekly for 1 month, then once a month for 3 months to ensure that missed medica	staff on how to appropriately chart refusals.

	12/16, 12/17, 12/18, 12/21, 12/23, 12/26, 12/30, 12/31/24, and 1/1/25. During an interview on 1/16/25 at 9:41 a.m., the Director of Nursing indicated the staff should have documented reattempts to administer the medications. A facility policy titled, "Resident Medication Administration" indicated "...Medications are to be administered as ordered by the provider." Based on record review and interview, the facility failed to ensure physician's orders were followed related to medications not administered as ordered for 1 of 7 residents reviewed. (Resident 2) Finding includes: The record for Resident 2 was reviewed on 1/15/25 at 10:14 a.m. Diagnoses included, but were not limited to, Alzheimer's disease. The resident was admitted to the facility on 5/1/23. The Service Plan, dated 12/6/24 and signed by the POA (power of attorney), indicated the resident had moderate dementia with significant short-term memory and possible long-term memory loss. The resident required assistance with medications due to cognitive		tions are being reoffered and documented in the correct way. Due Date: 2/23/2025	

loss.

A Physician's Order, dated 10/18/24, indicated sucralfate 1 gram, one tablet by mouth three times daily 30 minutes prior to meals for nausea and vomiting.

A Physician's Order, dated 10/18/24, indicated ondansetron tablet four milligrams tablet, one tablet by mouth every eight hours for nausea and vomiting.

The November 2024, December 2024, and January 2025 Medication Administration Records (MAR) indicated the ondansetron tablet and sucralfate tablet were coded not administered at 7:30 a.m. as resident was sleeping on the following dates: 11/6, 11/10, 11/13, 11/19, 11/20, 11/23, 11/28, 12/2, 12/8, 12/11, 12/14, 12/16, 12/17, 12/18, 12/21, 12/23, 12/26, 12/30, 12/31/24, and 1/1/25.

During an interview on 1/16/25 at 9:41 a.m., the Director of Nursing indicated the staff should have documented reattempts to administer the medications.

A facility policy titled, "Resident Medication Administration" indicated "...Medications are to be administered as ordered by the provider."

R 0273	Food and Nutritional Services - Deficiency 410 IAC 16.2-5-5.1(f) (f) All food preparation and serving areas (excluding areas in residents ' units) are maintained in accordance with state and local sanitation and safe food handling standards, including 410 IAC 7-24. Based on observation, record review and interview, the facility failed to ensure staff was knowledgeable about dishwasher temperatures and that dishwasher temperatures were monitored for 1 of 1 kitchen (Main kitchen). This had the potential to affect all 96 residents in the facility who received food from the kitchen. Finding includes: On 1/15/25 at 9:45 a.m. the kitchen was observed with the Dietary Manager (DM). The DM indicated she thought the dishwasher was a high temperature machine, not a chemical machine. The DM indicated the wash cycle should be 150 degrees and the rinse cycle should be 145 degrees. A dishwashing cycle was observed and the wash temperature was 160 degrees and the rinse cycle was 174 degrees. The dishwasher temperature log was reviewed. It had not been	R 0273	**R 273** 410 IAC 16.2-5-1.2(v)(1-6) Food and Nutritional Services-Deficiency **What Has Been Done to Correct?**	02/23/2025

	updated since August 2023. There was no policy related to dishwashing or dishwasher temperatures available for review. On 1/16/25 at 10:05 a.m., the Administrator provided a copy of the manufacturer's manual for the dishwasher. The manual indicated wash temperatures should be between 155-160 degrees and rinse temperatures 180-195 degrees. She indicated they were working on a policy for monitoring the dishwasher. Based on observation, record review and interview, the facility failed to ensure staff was knowledgeable about dishwasher temperatures and that dishwasher temperatures were monitored for 1 of 1 kitchen (Main kitchen). This had the potential to affect all 96 residents in the facility who received food from the kitchen. Finding includes: On 1/15/25 at 9:45 a.m. the kitchen was observed with the Dietary Manager (DM). The DM indicated she thought the dishwasher was a high temperature machine, not a chemical machine. The DM indicated the wash cycle should be 150 degrees and the rinse cycle should be 145 degrees. A dishwashing cycle was observed and the wash		How Will Recurrence Be Prevented?	ng machine. ED and Director of Culinary will audit temps daily for 2 weeks then weekly for 12 weeks to ensure proper temperatures. Dietary Director and ED Res	

	temperature was 160 degrees and the rinse cycle was 174 degrees. The dishwasher temperature log was reviewed. It had not been updated since August 2023. There was no policy related to dishwashing or dishwasher temperatures available for review. On 1/16/25 at 10:05 a.m., the Administrator provided a copy of the manufacturer's manual for the dishwasher. The manual indicated wash temperatures should be between 155-160 degrees and rinse temperatures 180-195 degrees. She indicated they were working on a policy for monitoring the dishwasher.		p o n si bl e:	
R 0354	Clinical Records - Noncompliance 410 IAC 16.2-5-8.1(g)(1-7) (g) A transfer form shall include the following: (1) Identification data. (2) Name of the transferring institution. (3) Name of the receiving institution and date of transfer. (4) Resident ' s personal property when transferred to an acute care facility. (5) Nurses ' notes relating to the	R 0354	**Section / Tag** **Violation** **Plan of Correction** **Complete?** **R 354** 410 IAC 16.2-5-1.2(v)(1 Wh at H DON educated nursing	02/23/2025

	resident ' s: (A) functional abilities and physical limitations; (B) nursing care; (C) medications; (D) treatment; and (E) current diet and condition on transfer. (6) Diagnosis. (7) Date of chest x-ray and skin test for tuberculosis. Based on record review and interview, the facility failed to ensure a transfer/discharge form was completed for 1 of 7 records reviewed. (Resident 8) Finding includes: The closed record for Resident 8 was completed on 1/15/25 at 12:14 p.m. Diagnoses included, but were not limited to, hypertension, hyperlipidemia, and gastroesophageal reflux disease. A Progress Note, dated 10/18/24 at 9:49 a.m., indicated the resident's daughter was at the facility to pick the resident up for discharge. All of Resident 8's medications were given to the daughter. There was a lack of documentation to indicate a			-6) Clinical Records-Noncompliance	as Been Done to Correct?	staff on all paperwork that needs to be filled out for each transfer/discharge. DON will receive copies of each transfer/discharge of every resident sent out of the facility indefinitely. DON will ensure that all charting is completed and accurat		

	transfer form was completed. There was a lack of documentation to indicate the resident's current condition, functional abilities or physical limitations, or the reason for the transfer. During an interview on 1/16/25 at 8:45 a.m., the Director of Nursing (DON) indicated the resident's daughter had picked the resident up and said she was discharging her. She would not tell the facility where they were going. They sent the resident's medication list and face sheet. They also sent the State Form Notice of Transfer or Discharge. The form did not include the resident's current condition, functional abilities or physical limitations, or reason for the transfer. A facility policy titled, "Transfer Out of Community" and received as current from the DON indicated, "...For all Transfers out of Community: Documentation will be complete in the Resident's Medical Record. Documentation should include: Details of change in condition requiring transfer..." Based on record review and interview, the facility failed to ensure a transfer/discharge form was completed for 1 of 7 records reviewed. (Resident 8) Finding includes:		Be Prevented?	e after each transfer or discharge. DON or designee will audit all transfers/discharge paperwork indefinitely, as they arise, to ensure that it is completed 100 percent and that it has been documented correctly in point click care.	

	The closed record for Resident 8 was completed on 1/15/25 at 12:14 p.m. Diagnoses included, but were not limited to, hypertension, hyperlipidemia, and gastroesophageal reflux disease. A Progress Note, dated 10/18/24 at 9:49 a.m., indicated the resident's daughter was at the facility to pick the resident up for discharge. All of Resident 8's medications were given to the daughter. There was a lack of documentation to indicate a transfer form was completed. There was a lack of documentation to indicate the resident's current condition, functional abilities or physical limitations, or the reason for the transfer. During an interview on 1/16/25 at 8:45 a.m., the Director of Nursing (DON) indicated the resident's daughter had picked the resident up and said she was discharging her. She would not tell the facility where they were going. They sent the resident's medication list and face sheet. They also sent the State Form Notice of Transfer or Discharge. The form did not include the resident's current condition, functional abilities or physical limitations, or reason for the transfer.		rs on Responsible:	r of Nursing

	A facility policy titled, "Transfer Out of Community" and received as current from the DON indicated, "...For all Transfers out of Community: Documentation will be complete in the Resident's Medical Record. Documentation should include: Details of change in condition requiring transfer..."			

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting provided it is determined that other safeguards provide sufficient protection to the patients. (See instructions.)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE