STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING B. WING	10/15/2025

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: October 14 and 15, 2025 Facility number: 010890 Residential Census: 106 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review completed on 10/17/25.	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 regulation.	
R 0042	Residents' Rights - Noncompliance 410 IAC 16.2-5-1.2(p) (p) Residents have the right to the examination of the results of the most recent annual survey of the facility conducted by the state surveyors, any plan of correction in effect with respect to the facility, and any subsequent surveys. Based on observation and	R 0042	The most recent annual survey results have been removed from behind the desk; State Binder has been clipped to the wall in a clearly visible and accessible area within the main lobby; to ensure that it is always available, to remain in compliance.	11/01/2025

	interview, the facility failed to ensure the most recent annual survey results were readily available for review. This had the potential to affect all 106 residents of the facility. Finding includes: A general tour of the facility was conducted on 10/15/25 at 10:45 a.m. There was a clear plastic bin hanging on the wall that contained a binder titled "Resident Rights." There were no binders containing survey results available to review. During an interview on 10/15/25 at 10:56 a.m., the Director of Nursing and the Executive Director indicated they had a resident that kept removing the binder and taking pages from it so they had placed the binder behind the front desk out of reach from the resident. The binder should have been in the clear plastic bin in the main lobby area. Based on observation and interview, the facility failed to ensure the most recent annual survey results were readily available for review. This had the potential to affect all 106 residents of the facility.		Concierge will be educated to ensure that survey binder is always available at the beginning and end of each shift to ensure that survey results remain available to the public. The Executive Director or designee will complete weekly checks for 4 weeks, then monthly for 3 months, to verify that the binder remains in place and is accessible. Findings will be reviewed during monthly QA meetings to determine if further monitoring is required.	

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R 0246	Health Services - Deficiency 410 IAC 16.2-5-4(e)(6) (6) PRN medications may be administered by a qualified medication aide (QMA) only upon authorization by a licensed nurse or physician. The QMA must receive appropriate authorization for each administration of a PRN medication. All contacts with a nurse or physician not on the premises for authorization to administer PRNs shall be documented in the nursing notes	R 0246	The QMA’s were immediately re-educated on the requirements to obtain nurse authorization prior to administering any PRN medications. DON has completed an audit of all PRN medications to ensure that no additional instances of noncompliance were identified. DON reviewed all PRN medications not used within the last 30 days. DON in-serviced all QMAs and	11/01/2025

	indicating the time and date of the contact. 2. A closed record review for Resident 8 was completed on 10/15/22 at 10:22 a.m. Diagnoses included, but were not limited to, dementia, hypertension, and diabetes mellitus. A Service Plan, dated 6/30/25, indicated the resident was confused and unable to self-administer her own medications. A Hospice Plan of Care was completed on 7/18/25. The August 2025 Physician's Order Summary (POS) indicated the following orders: - lorazepam (treats anxiety disorders) 0.5 mg every 2 hours as needed for anxiety - morphine sulfate (pain medication) 5 mg every 2 hours as needed for pain The August 2025 Medication Administration Summary (MAR) indicated the resident received the as needed medications on the following dates and times. - 8/9/25 at 2:00 a.m., the lorazepam was administered by QMA 3 - 8/9/25 at 4:51 a.m., the morphine sulfate was		nurses on PRN medication protocols, including when and how to obtain nurse authorization prior to administration. All new QMAs will be trained on this policy during orientation. A new QMA PRN audit form was implemented for use when PRN medications are requested or administered. Any non-compliance identified will result in immediate documented retraining and disciplinary action will occur as necessary. DON will audit all PRN administrations twice a week for 1 month, then once a week for 2 months. Audit results will be reviewed during monthly QA meetings to determine if continued monitoring is necessary.	

	administered by QMA 3 The record lacked any documentation the QMA received prior authorization from a licensed nurse before administering the as needed medications on the above dates and times. During an interview on 10/15/25 at 1:16 p.m., the DON indicated she was unable to provide any information the QMA had received prior authorization before administering the as needed medications. 3. Resident 6's record was reviewed on 10/15/25 at 9:00 a.m. Diagnoses included, but were not limited to, heart failure. A Physician's Order, dated 9/26/25, indicated lorazepam 0.5 milligram tablet, give 1 tablet every 4 hours as needed. The October 2025 MAR indicated QMA 1 administered lorazepam on 10/10/25 at 10:00 p.m. and 10/14/25 at 3:20 a.m. There was no documentation of the QMA receiving prior authorization from a licensed nurse before administering the as needed medication. During an interview on 10/15/25 at 10:39 a.m., the DON indicated the staff members were to call her directly anytime an as needed medication was			

administered. She was unable to find any documentation of the QMA receiving authorization to administer the medication.

Based on record review and interview, the facility failed to ensure QMAs received authorization from a licensed nurse prior to administering as needed (PRN) medications for 3 of 8 records reviewed. (Residents 5, 8 and 6)

Findings include:

1. Resident 5's record was reviewed on 10/14/25 at 1:32 p.m. Diagnoses was Alzheimer's Disease. She resided on the memory care unit.

A Physician's Order, dated 6/12/25, indicated to give mucus relief tablet 600 milligram (mg) every six hours as needed for congestion.

The September 2025 Medication Administration Record (MAR) indicated the medication was given on 9/28/25 by QMA 2. There was no documentation the QMA had approval from a licensed nursing prior to giving the medication.

During an interview on 10/15/25 at 10:38 a.m., the Director of Nursing (DON) indicated QMAs should contact her prior to giving a PRN medication and

document authorization in the progress notes.

2. A closed record review for Resident 8 was completed on 10/15/22 at 10:22 a.m. Diagnoses included, but were not limited to, dementia, hypertension, and diabetes mellitus.

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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 and interview, the facility failed to ensure a clean and sanitary kitchen related to ice build up in the walk-in freezer, food spilled on the floor in the freezer, food spillage and debris on shelves and a heavy buildup of grease and debris on the stovetop and oven. This had the potential to affect all 106 residents who received meals prepared in the main kitchen. Finding includes: During the initial kitchen tour with the Dietary Manager (DM) on 10/14/25 at 10:00 a.m., the following was observed: a. In the walk-in freezer there was a heavy build up of ice on the door frame and six boxes of food. The DM indicated one box was greens, but she was unable to identify the remaining boxes due to the heavy ice	R 0273	The ED, DM and/or Designee started a deep clean of the kitchen on 10/15/25. Ice buildup was cleared in addition, shelving, stovetops and ovens were fully cleaned. A comprehensive inspection of all kitchen areas, including dry storage, dishwashing, and serving areas, was conducted to ensure similar conditions did not exist elsewhere. No additional concerns were identified. The ED/DM reviewed all current cleaning schedules with staff and updated any areas that needed to be removed or added. The ED and DM printed daily, weekly, and monthly cleaning logs for the kitchen and were reviewed with the kitchen staff on 10/20/25. All kitchen staff were re-educated on sanitation standards and proper cleaning procedures, including the importance of maintaining a clean and safe food preparation environment. The ED or designee will review daily cleaning logs daily for the first 30 days,	11/01/2025

	accumulation. b. There was an open bag of hash browns spilled on the freezer floor and scattered food debris and spillage. c. There was dried food spillage on the side of the prep counter and food debris and spillage on the shelves below the counter. d. The stovetop and front of the oven had a heavy build up of grease and food debris. During an interview on 10/14/25 at 11:45 a.m., the DM indicated the freezer build up had been ongoing for about a month, and the boxes of food had been disposed of. She indicated the above items needed to be cleaned. Based on observation and interview, the facility failed to ensure a clean and sanitary kitchen related to ice build up in the walk-in freezer, food spilled on the floor in the freezer, food spillage and debris on shelves and a heavy buildup of grease and debris on the stovetop and oven. This had the potential to affect all 106 residents who received meals prepared in the main kitchen. Finding includes: During the initial kitchen tour with the Dietary Manager (DM) on 10/14/25 at 10:00 a.m., the		weekly for the next three months and then monthly thereafter. Any identified concerns will be addressed immediately and added to the QA concern log and then reviewed at the monthly Quality Assurance Performance Improvement meeting with team leadership.	

	following was observed: a. In the walk-in freezer there was a heavy build up of ice on the door frame and six boxes of food. The DM indicated one box was greens, but she was unable to identify the remaining boxes due to the heavy ice accumulation. b. There was an open bag of hash browns spilled on the freezer floor and scattered food debris and spillage. c. There was dried food spillage on the side of the prep counter and food debris and spillage on the shelves below the counter. d. The stovetop and front of the oven had a heavy build up of grease and food debris. During an interview on 10/14/25 at 11:45 a.m., the DM indicated the freezer build up had been ongoing for about a month, and the boxes of food had been disposed of. She indicated the above items needed to be cleaned.			
R 0349	Clinical Records - Noncompliance 410 IAC 16.2-5-8.1(a)(1-4) (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	R 0349	An audit of all residents receiving insulin and/or blood glucose monitoring was completed for the prior 30 days to ensure that all administrations and blood sugar readings were properly	11/01/2025

	with that responsibility. The records must be as follows: (1) Complete. (2) Accurately documented. (3) Readily accessible. (4) Systematically organized. Based on record review and interview, the facility failed to ensure resident records were complete and accurately documented related to insulin administration documentation for 1 of 8 resident records reviewed. (Resident 3) Finding includes: Resident 3's record was reviewed on 10/14/25 at 10:56 a.m. Diagnoses included, but were not limited to, type 2 diabetes mellitus. The Service Plan, dated 9/13/23, indicated the resident had diabetes mellitus. Interventions included, but were not limited to, blood sugar checks as ordered by the physician, staff to administer medication as ordered by the physician, observe for side effects and effectiveness, and report observed side effects/effectiveness to nurse. A Physician's Order, dated 9/3/25, indicated insulin aspart flexpen, inject 9 units		documented. All QMA's and nurses have been educated on checking BS prior to insulin administration and ensuring that it is documented correctly. QMA responsible will be counseled and re-educated on accurate and timely documentation regarding insulin administration and blood glucose monitoring upon return from FMLA. All new nurses and insulin certified QMAs will receive training as part of the orientation process. DON or designee will audit all insulin MAR's twice weekly for 90 days (3 months) to ensure BS are being documented and provide education and disciplinary action if warranted. Audit results and trends identified will be reviewed during monthly QA meetings to determine if continued monitoring is necessary.	

subcutaneously three times a day before meals and hold for blood sugar less than 150.

The October 2025 Medication Administration Record indicated the insulin aspart was not administered at 8:00 a.m. on 10/6/25, 10/8/25, 10/10/25, 10/11/25 and 10/12/25, at 12:00 p.m. on 10/8/25, and at 5:00 p.m. on 10/10/25 and 10/12/25. Each administration time was marked with "VS" indicating vital signs were outside of parameters. There were no documented blood sugars for those dates and times.

During an interview on 10/14/25 at 2:59 p.m., the Director of Nursing indicated she was unable to find any documentation of the blood sugars.

Based on record review and interview, the facility failed to ensure resident records were complete and accurately documented related to insulin administration documentation for 1 of 8 resident records reviewed. (Resident 3)

Finding includes:

Resident 3's record was reviewed on 10/14/25 at 10:56 a.m. Diagnoses included, but were not limited to, type 2 diabetes mellitus.

The Service Plan, dated

9/13/23, indicated the resident had diabetes mellitus. Interventions included, but were not limited to, blood sugar checks as ordered by the physician, staff to administer medication as ordered by the physician, observe for side effects and effectiveness, and report observed side effects/effectiveness to nurse.

A Physician's Order, dated 9/3/25, indicated insulin aspart flexpen, inject 9 units subcutaneously three times a day before meals and hold for blood sugar less than 150.

The October 2025 Medication Administration Record indicated the insulin aspart was not administered at 8:00 a.m. on 10/6/25, 10/8/25, 10/10/25, 10/11/25 and 10/12/25, at 12:00 p.m. on 10/8/25, and at 5:00 p.m. on 10/10/25 and 10/12/25. Each administration time was marked with "VS" indicating vital signs were outside of parameters. There were no documented blood sugars for those dates and times.

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correcting provided it is determined that other safeguards provide sufficient protection to the patients. (See instructions.)		
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURENicole Smith	TITLEDON	(X6) DATE10/30/2025