STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING B. WING	05/20/2026

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 the Investigation of Intakes 468283 and 468678. Intake 468283 - State deficiency related to the allegations is cited at R240. Intake 468878 - No deficiencies related to the allegations are cited. Survey date: May 19 and 20, 2026 Facility number: 010890 Residential Census: 113 This State Residential Finding is cited in accordance with 410 IAC (Indiana Administrative Code) 16.2-5. Quality review completed on 5/22/26.	R 0000	This plan of correction is not to be constructed 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 regulations.	
R 0240	Health Services - Deficiency	R 0240	DON and ADON conducted a comprehensive audit of all	05/27/2026

	410 IAC 16.2-5-4(d) (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 provide care as ordered related to the delay in reordering medication and providing medication with no order for 1 of 3 residents reviewed for pharmaceutical services. (Resident E) Finding includes: The record for Resident E was reviewed on 5/20/26 at 12:33 p.m. Diagnoses included, but were not limited to, hypertension (high blood pressure), mild cognitive impairment, and low back pain. The resident was re-admitted from rehab on 1/30/26. A Physician's Order, dated 9/5/25, indicated to administer one 10 milligram (mg) tablet by mouth daily. The order was put on hold on 1/4/26 due to hospitalization. The January 2026 Medication Administration Record (MAR) showed the medication had not been given on the following dates after the resident had returned to the facility: 1/31, 2/2, 2/3, 2/4, 2/5, 2/6, 2/7, 2/8, 2/9,		electronic charts in ECP and verified each residents medication by comparing medication records in PCC with those entered in ECP. This review was completed to ensure that all medications were accurately entered and that resident medication information was current and correct within the system. A process has been implemented requiring verification of all medication entries during admissions and readmissions by two nurses. DON or designee will audit all new admissions and readmissions medications monthly for three months, then quarterly for one year. Ongoing audits will be conducted routinely to monitor compliance and promptly identify and correct any discrepancies.	

2/10, 2/11, 2/12, 2/13, 2/14, 2/15, 2/16, 2/17, 2/18, 2/19, 2/20, 2/21, 2/22, and 2/23.

The medication was signed out on a paper MAR on 2/24/26.

A Nurses Note, dated 2/22/26 at 2:18 p.m., indicated the resident had a new order to start Atorvastatin 10 mg by mouth daily.

A Pharmacy Order Slip indicated the Atorvastatin was received and signed for on 2/23/26.

A Physician's Order, dated 2/25/26, indicated to administer one 10 milligram (mg) tablet by mouth at bedtime for hyperlipidemia (high cholesterol).

A Care Plan, dated 3/1/26, indicated the resident required full assistance with pharmacy support. Full assistance was required for reordering medication. The resident required observation of cognitive, behavior, and psychosocial skills.

During an interview on 5/19/26 at 2:30 p.m., the Director of Nursing (DON) indicated Resident E returned from the rehabilitation facility and the family was upset that there was a medication error and indicated the resident had not received

	one of her medications. There was a medication error, and the resident went without the medication for three days. The family requested the MAR records, and they initiated 72-hour monitoring with no concern. They spoke with the family and provided them with all necessary documentation. They felt the resident went without her Atorvastatin for much longer than three days. The resident had just returned after being gone almost a month. During an interview on 5/20/26 at 2:27 p.m., the Assistant Director of Nursing (ADON) indicated the resident came back from rehab on 1/30/26. The facility transitioned over to their new electronic system in February and pharmacy discontinued the order on 1/31/26. The resident should have had the medication reordered. During an interview on 5/20/26 at 2:30 p.m., the Executive Director indicated she understood the concern and had no additional information to provide.			

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	TITLEDON	(X6) DATE06/03/2026

SIGNATURENicole Smith		