STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING B. WING	02/19/2026

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 Intake 467724. Intake 467724 - State deficiency related to the allegations is cited at R349. Survey date: February 19, 2026 Facility number: 010890 Residential Census: 106 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review completed on 2/24/26.	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 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 with that responsibility. The records	R 0349	DON and ADON completed an audit of all falls for the past month to ensure all post charting has been completed. Education will be provided to employees who have not completed the post charting by 3/31/2026.	03/03/2026

	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 maintain clinical records that were complete and accurately documented related to 72-hour follow-up documentation after an abuse allegation for 1 of 2 sampled residents. (Residents B and C) Findings include: 1. The record for Resident B was reviewed on 2/19/26 at 9:28 a.m. Diagnoses included, but were not limited to, delirium, dementia, and high blood pressure.		DON or designee to complete incident audit forms twice weekly for 3 months, then weekly for 3 months. DON to continue incident audit forms indefinitely.	

The Service Plan, dated 11/18/25 and reviewed on 1/31/26, indicated the resident had memory loss related to dementia. The resident displayed deficits in judgment and required support to make appropriate decisions regarding care and environment. The resident had an alleged abuse incident on 1/31/26 and interventions were to increase safety checks and initiate 72-hour charting.

An Indiana Department of Health (IDOH) Facility Reported Incident was dated 1/31/26 at 1:01 a.m. The report indicated Resident B and Resident C had both been found in a state of undress. An investigation was initiated and safety checks and 72-hour charting were started.

Nurse's Alert notes were completed on the resident at the following times:

2/1/26 at 2:01 a.m.

2/2/26 at 12:22 p.m.

2/3/26 at 1:32 p.m.

2/3/26 at 2:34 p.m.

The record lacked a social worker progress note.

During an interview on 2/19/26 at 11:19 a.m., the Director of Nursing (DON) indicated the

	staff did not fully complete the 72- hour checks on Resident B and Resident C. During an interview on 2/19/26 at 11:58 p.m., the DON indicated they do not have a social worker and there had never been a social worker since she's been with the company. She was unsure why their policy would include a social worker. 2. The record for Resident C was reviewed on 2/19/26 at 10:28 a.m. Diagnoses included, but were not limited to, high blood pressure, dementia, and high cholesterol. The Service Plan, dated 12/4/25 and reviewed on 1/31/26, indicated the resident required support to make appropriate decisions regarding care and environment and needed time when responding due to word seeking. The resident had an alleged abuse incident on 1/31/26 and interventions were to increase safety checks and initiate 72-hour charting.			

An Indiana Department of Health (IDOH) Facility Reported Incident was dated 1/31/26 at 1:01 a.m. The report indicated Resident B and Resident C had both been found in a state of undress. An investigation was initiated and safety checks and 72-hour charting were started.

Nurse's Alert notes were completed on the resident at the following times:

2/1/26 at 2:02 a.m.

2/3/26 at 1:39 a.m.

2/3/26 at 2:37 p.m.

The record lacked a social worker progress note.

During an interview on 2/19/26 at 11:19 a.m., the Director of Nursing (DON) indicated the staff did not fully complete the 72- hour checks on Resident B and Resident C.

During an interview on 2/19/26 at 11:58 p.m., the DON indicated they do not have a social worker and there had never been a social worker since she's been with the company. She was unsure why their policy would include a social worker.

A facility policy titled, "Abuse, Neglect, and Misappropriation Policy and Procedure" and

	received as current from the Director of Nursing, indicated, "...Protection: ..." "... The facility protects the residents from harm during an investigation. The facility monitors the resident during this time for harm or psychosocial issues. This will be done by observation and evaluating the resident/elder for changes in habit, vital signs, signs of depression, scared, ect ..." "The social worker will talk to the residents and ensure the resident feels safe from harm ..."			

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 SIGNATURENicole Smith	TITLEDON	(X6) DATE03/06/2026