STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
		A. BUILDING 00 B. WING	01/16/2025

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

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R 0000 Bldg. 00	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	**R 000** 410 IAC 16.2-5-1.2(v)(1-6) ___ Yes ___ No What Has Been Done to Correct? Please accept our Plan of Correction from the annual survey conducted at Brentwood at LaPorte on 1-15-25. We respectfully request a desk review in this matter. Thank you for your consideration. 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. How Will Recurrence Be Prevented? Person Responsible: Due Date: 2/23/2025	
R 0092 Bldg. 00	410 IAC 16.2-5-1.3(i)(1-2) Administration and Management - Noncompliance 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:	R 0092	**R 092** 410 IAC 16.2-5-1.2(v)(1-6) Administration and Management-Noncompliance ___ Yes _X_ No	02/23/2025

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Nicole Smith	DON	01/31/2025

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	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.		What Has Been Done to Correct? ED and Maintenance director audited the fire drills for the year and Maintenance director to run additional fire drill for night shift that was missed. How Will Recurrence Be Prevented? The ED and Maintenance 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 shift is being trained each Quarter. Person Responsible: ED and Maintenance Director Due Date: 2/23/2025	
R 0148 Bldg. 00	410 IAC 16.2-5-1.5(e)(1-4) Sanitation and Safety Standards - Deficiency 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 in the notebook that indicated how often fire alarms, generators, sprinklers or other mechanical systems needed to be inspected or have preventative maintenance.	R 0148	**R 148** 410 IAC 16.2-5-1.2(v)(1-6) Sanitation and Safety Standards-Deficiency ___ Yes _X_ No What Has Been Done to Correct? HVAC 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	02/23/2025

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	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.		Due Date: 2/23/2025	
R 0217 Bldg. 00	410 IAC 16.2-5-2(e)(1-5) Evaluation - Deficiency 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	R 0217	**R 217** 410 IAC 16.2-5-1.2(v)(1-6) Evaluation - Deficiency ___ Yes _X_ No What Has Been Done to Correct? DON and ADON completed an audit to ensure all services plans are up to date. _X_ Yes ____ No 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 indefinitely. DON and ADON to complete audit of all service plans biweekly for the next 90 days.	02/23/2025

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	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."		Person Responsible: DON and ADON Due Date: 2/23/2025	
R 0241 Bldg. 00	410 IAC 16.2-5-4(e)(1) Health Services - Offense 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 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.	R 0241	**R 241** 410 IAC 16.2-5-1.2(v)(1-6) Health services - Offense ___ Yes _X_ No 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 staff on how to appropriately chart refusals. __X__ Yes ____ No How Will Recurrence Be Prevented? 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 medications are being	02/23/2025

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	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."		reoffered and documented in the correct way. Person Responsible: DON Due Date: 2/23/2025	
R 0273 Bldg. 00	410 IAC 16.2-5-5.1(f) Food and Nutritional Services - Deficiency 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	R 0273	**R 273** 410 IAC 16.2-5-1.2(v)(1-6) Food and Nutritional Services-Deficiency ___ Yes _X_ No What Has Been Done to Correct? Dishwasher Temp Log was implemented on 01/15/25, and temps are checked and documented twice daily by kitchen staff. Once on 1st shift and once on 2nd shift. Ecolab provided the	02/23/2025

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	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 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.		community with a form that contains information on proper functioning for high temp sanitizing machines that have been posted next to the dishwashing machine. ____ Yes ____ No How Will Recurrence Be Prevented? ED and Director of Culinary will audit temps daily for 2 weeks then weekly for 12 weeks to ensure proper temperatures. Person Responsible: Dietary Director and ED Due Date: 2/23/2025	
R 0354 Bldg. 00	410 IAC 16.2-5-8.1(g)(1-7) Clinical Records - Noncompliance 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	R 0354	**Section / Tag** **Violation** **Appeal?** **Plan of Correction** **Complete?** **R 354** 410 IAC 16.2-5-1.2(v)(1-6) Clinical Records- Noncompliance ___ Yes _X_ No What Has Been Done to Correct? DON educated nursing staff on all paperwork that needs to be filled out for each transfer/discharge. DON will receive copies of each transfer/discharge of every	02/23/2025

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	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. 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..."		resident sent out of the facility indefinitely. __X__ Yes ____ No How Will Recurrence Be Prevented? DON will ensure that all charting is completed and accurate 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. Person Responsible: Director of Nursing Due Date: 2/23/2025	