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	04/25/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
BRENTWOOD AT ELKHART ASSISTED LIVING	3109 E BRISTOL ELKHART, IN 46514

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R 0000 Bldg. 00	This visit was for a State Residential Licensure Survey. Survey dates: April 24 & 25, 2025 Facility number: 010065 Residential Census: 75 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality Review completed on 5/5/2025	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. The provider respectfully requests a desk review with paper compliance be considered. ="" b=""> ="" b="">	
R 0033 Bldg. 00	410 IAC 16.2-5-1.2(h)(1-2) Residents' Rights - Noncompliance Based on observation, record review and interview, the facility failed to provide phone numbers and addresses at admission and post the phone numbers and addresses of advocacy agencies for 75 of 75 residents reviewed for resident rights. Findings include: 1. On 4/24/2024 at 9:40 A.M., a tour of the facility was completed. Information for the facility area advocacy agencies was posted around the residents' mailboxes, but lacked the following information. - There was no statement or contact information that informed the resident that they could file a complaint with the facility director concerning resident abuse, neglect, misappropriation of resident property, and other practices of the facility.	R 0033	All residents have potential to be affected by this deficient practice. Addendum to be created by 6/7/25 with all agency addresses and phone numbers available and distributed to all current residents. An addendum created for current residents will be provided to all new residents at admission. Information posted in the mailroom will be audited 1x weekly for 30 days, 2x monthly for 60 days, and 1x monthly indefinitely to identify any changes and need for updates. Indefinite audits of this corrective action will be monitored via community Quality Assurance program monthly.	06/07/2025

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Megan Crooks	Executive Director	05/17/2025

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	- There was no address for the Indiana Department of Health. - There was no address for Adult Protective Services. - There was no address or phone number for the local area agency on aging. - There was no address or phone number for the local mental health service provider. During an interview, on 4/25/2025 at 11:30 A.M., the Executive Director viewed the available addresses and phone numbers of the advocacy agencies list around the residents' mailboxes. She indicated the only advocacy agency provided with an address was the Ombudsman's office. She indicated an address was not provided for the Indiana Department of Health or Adult Protective Services. She indicated there was no information posted for the local mental health provider or the council for aging. She indicated this information should have been posted for the residents of the facility. 2. On 4/25/2025 10:35 A.M., the document titled, "Resident Policies and Agreement Assisted Living - Indiana" was reviewed. The document indicated, " ...II) Terms and Obligations ...E) Termination ...13) Grievances ...Residents have the right to express their complaints and dissatisfactions without fear of reprisal ...If you feel your concern has not been addressed, or you would like to contact someone outside of the organization, you can call the local ombudsman or other organizations, as necessary ...." The document failed to list the addresses for the local ombudsman's office, adult protective services and the local area agency on aging. The document did not have the addresses and phone numbers for the Indiana Department of Health or			

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	the local mental health service provider. During an interview, on 4/25/2025 at 11:30 A.M., the Executive Director indicated the admission packet did not provide the addresses of the local ombudsman's office, adult protective services and the local area agency on aging. She indicated the admission packet did not give the addresses and phone numbers for the Indiana Department of Health or the local mental health service provider. A policy was requested for providing and posting agency advocacy information, on 4/25/2025 at 11:26 A.M. A policy was not provided and the Executive Director indicated the facility followed the State regulations related to providing and posting agency advocacy information.			
R 0036 Bldg. 00	410 IAC 16.2-5-1.2(k)(1-2) Residents' Rights- Deficiency Based on record review and interview, the facility failed to notify the physician of abnormal blood sugars for 2 of 8 residents reviewed for quality of care. (Residents 6 & 2) Findings include: 1. A record review for Resident 6 was completed on 4/24/2025 at 1:02 P.M. Diagnoses included, but were not limited to: diabetes mellitus type 2, congestive heart failure and chronic kidney disease stage 3. A Physician's Order, dated 1/21/2025 through 3/7/2025, indicated Lantus insulin 30 units subcutaneously at bedtime daily was to be administered. A Physician's Order, dated 3/7/2025, indicated	R 0036	2 residents found to have been affected by this deficient practice, but all residents requiring blood glucose monitoring have potential to be affected. Inservice to be completed with applicable staff by DON by 6/7/25, continued education and discipline to be carried out as necessary. Doctors of all residents requiring blood glucose monitoring have been contract to confirm or update notification parameters. Follow ups will be completed as needed until all orders have been confirmed or updated. DON or designee will obtain and review 24-hour report daily. Change of condition form to be	06/07/2025

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	Lantus insulin 10 units subcutaneously at bedtime daily was to be administered. A Physician's Order, dated 1/27/2025, indicated Humalog insulin 5 units subcutaneously three times a day before meals was to be administered. A Physician's Order, dated 1/23/2025, indicated Lispro insulin sliding scale beginning at 110 mg/dL three times a day before meals was to be administered. Blood Sugar assessments included the following recordings: -2/19/2025 7:25 A.M. 65.0 mg/dL (milligram per deciliter) -2/21/2025 7:40 A.M. 51.0 mg/dL -2/22/2025 7:26 A.M. 65.0 mg/dL -2/23/2025 7:58 A.M. 53.0 mg/dL -2/23/2025 08:05 67.0 mg/dL -2/24/2025 11:47 A.M. 60.0 mg/dL -3/3/2025 8:00 A.M. 43.0 mg/dL There was no documentation in the medical record of the physician being notified of the low blood sugars. A normal target range blood sugar for a diabetic was 80-130 mg/dL. A Service Plan initiated on 1/17/2025, indicated Resident 6 had diabetes mellitus and would be free from any signs or symptoms of hyperglycemia (high blood sugar) or hypoglycemia (low blood sugar). Interventions included, but were not limited to: - Blood sugar checks as ordered by the physician. -Staff would administer medication as ordered by the physician, observe for side effects and effectiveness and report observed side effects/effectiveness to the nurse. -Identify areas of non-compliance or other		implemented with staff including occurrence, staff involved, MD notified, family notified, pharmacy notified. Form will be uploaded to PCC. Actions will be performed 1x daily for 30 days, 1x weekly for 60 days, and 1x monthly indefinitely. Audit will be performed by 6/7/25 for all residents receiving insulin or with orders for blood glucose checks, including orders in PCC with parameters for blood sugars. Audit to be completed 2x weekly for 60 days, 1x weekly for 90 days, and 1x monthly indefinitely. Indefinite audits of this corrective action will be monitored via community Quality Assurance program monthly.	

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	challenges with diabetic management. Educate and assist through challenges and provide referral as needed. During an interview, on 4/24/2025 at 2:41 P.M., a sister facility's Director of Nursing indicated the physician should have given parameters to reported blood sugars out of range and the facility staff should have informed the physician of blood sugar levels below 70 mg/dL. 2. The record for Resident 2 was reviewed on 4/24/2025 at 1:15 P.M. Diagnoses included, but were not limited to hypertension, diabetes, heart failure and depression. Current Physician Orders, dated 4/25/2025, included an order for Humalog insulin per sliding scale. If the blood sugar was over 450, staff should call the Nurse Practitioner. The January Medication Administration Record (MAR) indicated, on January 1/29/2025, Resident 2's blood sugar level was 479. Resident 2's record lacked the documentation to show the Nurse Practitioner or physician had been notified of the high blood sugar level. During an interview, on 4/24/2025 at 2:50 P.M., the Director of Nursing indicated the Nurse Practitioner should have been notified of the high level and the notification should have been documented in the residents record. A policy was requested for Notifying the Physician/Nurse Practitioner for abnormal lab values on 4/25/2025, but one was not provided prior to the survey exit. The Director of Nursing indicated the facility followed the State Regulations.			

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R 0042 Bldg. 00	410 IAC 16.2-5-1.2(p) Residents' Rights - Noncompliance Based on observation, record review and interview, the facility failed to make readily available the most recent annual survey with the plan of correction for 75 of 75 residents reviewed for resident rights. Finding includes: During an initial tour, on 4/24/2025 at 9:40 A.M., a purple binder was located at the facility's foyer of the facility titled, "Most Recent Surveys and Plan of Corrections". The binder had a survey letter, dated 6/26/2024, from the Indiana Department of Health for the annual survey conducted on 6/13/2024. The survey document, 2567, which described the cited facility deficiencies and the facility's plan of correction was not available for review. During an interview, on 4/24/2025 at 2:58 P.M., the Executive Director reviewed the facility binder. She indicated the prior year's survey results on the 2567 form and the plan of correction should have been in the facility binder for review. A policy was requested for disclosure of annual survey results, on 4/25/2025 at 11:26 A.M. A policy was not provided, and the Executive Director indicated the facility followed the State regulations related to providing annual survey results.	R 0042	All residents have potential to be affected by this deficient practice. Missing surveys and POCs have been added to the Survey binder. Audit will be completed 1x weekly for 60 days, and 1x monthly indefinitely. Indefinite audits of this corrective action will be monitored via community Quality Assurance program monthly.	06/07/2025
R 0120 Bldg. 00	410 IAC 16.2-5-1.4(e)(1-3) Personnel - Noncompliance Based on record review and interview, the facility failed to ensure newly hired staff members	R 0120	All residents have potential to be affected by this deficient practice.	06/07/2025

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	received six hours of initial dementia training for 2 of 5 staff members reviewed for in-services. (CNA 4 & LPN 5) Finding includes: On 4/25/2025 at 11:15 A.M., a review of the employee records was completed. The employee records for CNA 4 and LPN 5 lacked documentation of six hours of dementia training for both employees. CNA 4 was hired on 9/23/2024 and LPN 5 was hired on 8/7/2024. During an interview on 4/25/2025, at 12:05 P.M., the Administrator indicated CNA 4 and LPN 5 should have had the required six hours of dementia training. On 4/25/2025 at 12:10 P.M., a policy was requested regarding dementia in-services but one was not provided prior to the survey exit.		Audit of all associate training and in-service of expectations with training to be completed by 6/7/25. Any associate not in compliance will be taken off the schedule until trainings are up to date. Audits will be completed 1x weekly for 60 days, 2x monthly for 90 days, and 1x monthly indefinitely. Indefinite audits of this corrective action will be monitored via community Quality Assurance program monthly.	
R 0123 Bldg. 00	410 IAC 16.2-5-1.4(h)(1-10) Personnel - Nonconformance Based on record review and interview, the facility failed to ensure employee records included signed job descriptions for 4 of 5 staff members reviewed for employee records (CNA 4, LPN 5 & Culinary Aide 6). Finding includes: On 4/25/2025 at 11:20 A.M., an employee record review was completed for CNA 4, LPN 5 and Culinary Aide 6. All four employees had been newly hired in the past 12 months. The personnel files lacked documentation a job description had been signed by the employees	R 0123	All residents have potential to be affected by this deficient practice. Audit of all associate files to be completed by 6/7/25. All staff meeting held 5/13/25, all associates provided current job descriptions with signature requested. Audit of associate files will be completed 1x weekly for 60 days and 1x monthly indefinitely. Indefinite audits of this corrective action will be monitored via community Quality Assurance program monthly.	06/07/2025

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	upon their hire. During an interview on 4/25/2025 at 12:05 P.M., the Administrator indicated the employees should have had signed job descriptions. On 4/25/2025 at 11:08 A.M., the Administrator provided a policy titled, "Personnel Files," no date and indicated it was the policy currently being used by the facility. The policy indicated "...Procedure: Each employee will have a personnel file which may include the following: 9. Signed copy of job description...."			
R 0216 Bldg. 00	410 IAC 16.2-5-2(c)(1-4)(d) Evaluation - Noncompliance Based on record review and interview, the facility failed to obtain an admission weight for 1 of 8 residents reviewed for weights. (Resident 6) Finding includes: A record review for Resident 6 was completed on 4/24/2025 at 1:02 P.M. Diagnoses included, but were not limited to: diabetes mellitus type 2, congestive heart failure and chronic kidney disease stage 3. Resident 6 admitted to the facility on 1/21/2025. The first recorded weight in the medical record was on 3/12/2025. During an interview, on 4/24/2025 at 2:41 P.M., a sister facility's Director of Nursing indicated a weight should be obtained at admission. A policy was provided, on 4/25/2025 at 12:04 P.M., by the Executive Director. The policy titled,	R 0216	1 resident was found to have been affected by this deficient practice but all residents have potential to be affected. Resident weights will be obtained on all new admissions. DON or designee will review and sign at time of admission with resident, family/representative. Admission audit form to be implemented on all new admissions to ensure all necessary information is collected. Admission audit form will include all required assessments, service plan completion, vitals, diagnoses, immunizations, orders, admission note, height, weight, emergency contacts, PCP, preferred pharmacy/hospital, code status, and TB. Inservice to be completed by 6/7/25 for all applicable associates by DON.	06/07/2025

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	"Weight Monitoring". The policy did not address obtaining a resident's weight at admission.		All new admit charts will be audited 1x weekly for 60 days, 2x monthly for 90 days, and 1x month indefinitely. Indefinite audits of this corrective action will be monitored via community Quality Assurance program monthly.	
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 completed, dated and signed by the staff member completing the form and the resident and/or their representative for 3 of 7 residents reviewed for service plans. (Residents 2, 5 and 6) Finding includes: 1. The record for Resident 2 was reviewed on 4/24/2025 at 1:15 P.M. Diagnoses included, but were not limited to depression, diabetes, hypertension and anemia. The Service Plan Report, dated 11/19/2024, lacked the resident/representative and staff signatures. The Service Plan Report, dated 2/28/2025, lacked the resident/representative and staff signatures. 2. The record for Resident 5 was reviewed on 4/24/2025 at 2:28 P.M. Diagnoses included but were not limited to Alzheimer's disease, diabetes and hypertension. The Service Plan Report, dated 10/15/2024, lacked the resident/representative and staff signatures.	R 0217	3 residents were found to have been affected by this deficient practice, but all residents have potential to be affected. Service plans will be completed at admission and reviewed/signed by both DON or designee and resident, family/representative. Service plans will be reviewed for accuracy and completion upon admission, change of condition, and quarterly. Audit of all resident services plans to be completed by 6/7/25 to ensure all service plans are accurate, complete, and signed. Audits will continue to be completed 1x weekly for 60 days, 2x monthly for 90 days and 1x month indefinitely. Admission audit form will be implemented for all residents indefinitely. Indefinite audits of this corrective action will be monitored via community Quality Assurance program monthly.	06/07/2025

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	The Service Plan Report, dated 1/21/2025, lacked the resident/representative and staff signatures. During an interview, on 4/25/2025 at 2:40 P.M., the Director of Nursing indicated if there was a change in the resident's service plan, it would be updated and reviewed with the resident and/or their responsible party. He then indicated he had the resident sign the service plan and he placed a copy of the service plan in the service plan book and on the residents' chart. 3. A record review for Resident 6 was completed on 4/24/2025 at 1:02 P.M. Diagnoses included, but were not limited to: diabetes mellitus type 2, congestive heart failure and chronic kidney disease stage 3. Resident 6 was admitted to the facility on 1/21/2025. A Level of Care Assessment/Service Plan document was completed on 1/17/2025 as part of a pre-admission assessment. The Service Plan initiated, on 1/17/2025, was available in the electronic health record, but was not signed by the resident. During an interview with the Director of Nursing from another facility in the same corporation, on 4/24/2025 at 2:41 P.M., she indicated she could not locate a signed Service Plan document for Resident 6. She indicated the Service Plan document should be signed by the resident. A policy was provided, on 4/25/2025 at 12:04 P.M., by the Executive Director. The policy titled, "Coordination/Individualization of Services", did not address the need for resident or resident representative to sign the service plan.			

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R 0273 Bldg. 00	410 IAC 16.2-5-5.1(f) Food and Nutritional Services - Deficiency Based on observation, interview and record review, the facility failed to ensure food was stored and prepared in a sanitary manner in 1 of 1 kitchens. This deficient practice potentially affected 75 of 75 residents in the building who consumed food from the kitchen. Findings include: During a kitchen observation, on 4/24/2025 at 9:30 A.M. with the Dietary Manager, the following was observed: In the walk-in freezer: - an opened bag of waffle fries not sealed tightly. - an opened bag of french fries not sealed tightly. - an opened package of hash brown potatoes not sealed tightly. - an opened box of fish not sealed tightly. - an opened bag of peas not sealed tightly. - chicken patty's wrapped in plastic wrap not labeled or dated. In the walk-in cooler: - an opened bag of lettuce with no used by date. - an opened and undated American cheese slices wrapped in plastic not sealed tightly. - Pasta cheese wrapped in plastic with no opened date or used by date. - an opened bag of shredded cheddar cheese with no received date or opened date. In the dry storage area: - an opened box of crushed graham crackers not sealed tightly. - a large brown stain on the floor underneath a wire shelf. - a sleeve of crackers with a used by date of	R 0273	All residents have potential to be affected by this deficient practice. Daily audits of walk in freezer, walk in cooler, and dry storage will be completed by Direct of Dietary servicer or designee daily for 60 days, 2x weekly indefinitely to ensure food is stored and labeled properly. Inservice to be completed with all dietary associates by 6/7/25 on storage of food, expirations dates, and cleaning. Thorough cleaning check list to be implemented for all areas of kitchen, audit to be completed daily for 60 days, 2x weekly for 90 days and 1x monthly indefinitely. Further education and discipline will be completed as necessary with all associates. Stock of date labels and proper storage containers to be completed 2x weekly for 60 days, 1x weekly for 90 days and 1x monthly indefinitely. Indefinite audits of this corrective action will be monitored via community Quality Assurance program monthly.	06/07/2025

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	3/20/2025. During a return kitchen observation, on 4/25/2025 at 9:20 A.M. with the Dietary Manager, the following was observed: - four steamer pans were stored as clean but had dried specs of food on them. - spatulas, stored as clean, had dried food on them. - a large and a medium sized cooking pot, stored as clean, had dried food particles on them. During an interview, on 4/24/2025 at 10:10 A.M., the Dietary Manager indicated the foods should have been sealed tightly, labeled with dates and removed if expired. During an interview, on 4/25/2/025 at 9:49 A.M., the Dietary Manager indicated the steamer pans and the other dirty items should have been cleaned. On 4/25/2025 at 10:24 A.M., the Dietary Manager provided the policy titled, "Labeling and Dating for Safe Storage of Food", undated, and indicated the policy was the current one used by the facility. The policy indicated"...All products should be dated upon receipt. All products should be dated when opened. Use Use-By dates on all food once opened and stored under refrigeration... Store food in approved food storage containers... When food is taken out of an original container write the name of the food being stored on the container, the placed date, and the Use-By date...." On 4/25/2025 at 10:15 A.M., the Dietary Manager provided the policy titled, "How to Clean and Sanitize Pots, Pans, Utensils, and Dishes', undated, and indicated the policy was the one			

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	04/25/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
BRENTWOOD AT ELKHART ASSISTED LIVING	3109 E BRISTOL ELKHART, IN 46514

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	currently used by the facility. The policy indicated, " 1) ...Scrape and flush out food particles... 5) Air dry... inspect, and store dry...."			